MEDICATION ADMINISTRATION CONSENT FORM PRESCRIPTION/OVER-THE-COUNTER POWHATAN COUNTY PUBLIC SCHOOLS

Student's Name:		
Mailing Address:		
Grade:	Date of Birth:	
School:		
that I have read and understand Public Schools. I authorize a re- medication with my child's phy	I the Medication Admini- epresentative of the school ysician and/or EMS perse	. I give my while in school. I hereby acknowledge stration Policy for Powhatan County ol to share information regarding this onnel. I understand that school employees ess otherwise instructed by me.
Parent/Guardian Signature	Da	ite
Home Phone#	Work Phone#	Cell Phone #
Medication:		
Reason Given:		
Dosage/Time Given:		
Anticipated Length of Treatme	nt:	
Physician's Name:		Phone#:
	TIONS TO BE GIVEN BOVE INFORMATIO	AT SCHOOL. THIS STATEMENT N AND MAY BE FAXED FROM THE
(A separate form must	Administration Policy a be filled out for each in st be filled out for each	
ANY UNUSED MEDICATION MUMEDICATION NOT PICKED UP PERSONNEL.		IE LAST DAY OF SCHOOL. ANY CHOOL WILL BE DISCARDED BY CLINIC
	For clinic use	•
		cked up:
	Parent signature:	
	School nurse signat	uic.