Albemarle County Public Schools
Parent’s Request for Giving Medication at School

Fax Numbers:

- Agnor-Hurt 974-7046  Stone Robinson 296-7645
- Baker-Butler 964-4684  Stony Point 973-9751
- Broadus Wood 973-3833  Woodbrook 973-0317
- Brownsville 823-5120  Yancey 974-8061
- Cale 293-2067  Burley 984-4975
- Crozet 823-6470  Henley 823-2711
- Greer 973-0629  Jouett 975-9325
- Hollymead 978-3687  Sutherland 975-0852
- Meriwether Lewis 979-3850  Walton 296-6648
- Murray Elem. 979-5416  AHS 974-4335
- Red Hill 293-7300  Monticello 244-3104
- Scottsville 286-2442  Murray High 979-6479
- WAHS 823-8711

Parent's Request for Giving Medicine at School

Please send this form to the school when needed. All areas on this form must be completed for us to administer the medication. Please Print.

Please have the School Nurse, or a member of school staff, administer to: ____________________________
the following medication: ____________________________
(name of child)
(Check one)

____ Certain prescription medication specified below or
____ Non-prescription medication specified below.

I understand that the person at the school who will administer this medication or treatment may be inexperienced and untrained in this requested service and state, without reservation, that I shall not hold him/her or the Albemarle County School Board liable in any way for harm or injury that may be experienced by my child as a result of this service. I also understand I am to provide all medication administered to my child in its original container.

My signature below serves as permission for the school nurse to contact the physician named below to discuss this medication or to obtain a signature

Date of Order:

Name of Medication: ____________________________ Brand Name: ____________________________

Exact dosage to be given: ____________________________ Time of day to be administered: ____________________________

Reason for medication: ____________________________

Duration for medication: ____________________________

Special Instructions: ____________________________

_________________________ ____________________________ ____________________________
Signature of Physician/Date Name of Parent Home Telephone
(for prescription medication)

_________________________ ____________________________ ____________________________
Physician telephone Signature of Parent or Guardian/Date Daytime Telephone
(for prescription medication) (for all medication)