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

School          Phone          Fax          School          Phone          Fax
Agnor-Hurt  973-5211          974-7046      Stony Point  973-6405          973-9751
Baker-Butler  974-7777          964-4684      Woodbrook  973-6600          973-0317
Broadus Wood  973-3865          973-3833      Burley       295-5101          984-4975
Brownsville  823-4658          823-5120      Henley       823-4393          823-2711
Cale           293-7455          293-2067      Jouett       975-9320          975-9325
Crozet         823-4800          823-6470      Sutherland  975-0599          975-0852
Greer           973-8371          973-0629      Walton       977-5615          296-6648
Hollymead     973-8301          978-3687      Albemarle  975-9300          974-4335
Meriwether Lewis  293-9404         979-3850      Monticello  244-3100          244-3104
Murray Elem.   977-4599          979-5416      Murray High  296-3090          979-6479
Red Hill       293-5332          293-7300      Western Albemarle  823-8700          823-8711
Scottsville   286-2441          286-2442      Learning & Growth  974-8070          979-6479
Stone Robinson 296-3754          296-7645

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 school staff to administer the medication. Please print.

Please have the school nurse, or a member of school staff, administer to: __________________________________ (name of child)

the following medication: ____________________________________________

(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 understand I am to provide all medication administered to my child in its original container. I realize medical information associated with the use of this medication may be disclosed to school employees with supervisory authority for my child. For prescription medication, my signature below shall be deemed consent for the school nurse to contact the physician named below for signature or to discuss the medication.

Date of Order: _______________________         Name of medication:_______________________________

Exact dosage to be given:__________________________  Time of day to be administered: __________________

Reason for medication: _____________________________

Duration for medication: ___________________________

Special Instructions: ______________________________

Name of Physician/Date
(for prescription medication)

Name of Parent
Home Telephone

Physician Signature
(for prescription medication)

Signature of Parent or Guardian/Date
(for all medication)

Daytime Telephone