**Albemarle County Public Schools**

**Parent’s Request for Giving Medicine at School**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **School** | **Phone** (area code 434) | **Fax** (area code 434) |  | **School** | **Phone** (area code 434) | **Fax** (area code 434) |
| 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 |
| Crozet | 823-4800 | 823-6470 |  | Journey | 975-9320 | 975-9325 |
| Greer | 973-8371 | 973-0629 |  | Lakeside | 975-0599 | 975-0852 |
| Hollymead | 973-8301 | 978-3687 |  | Walton | 977-5615 | 296-6648 |
| Ivy | 293-9304 | 979-3850 |  | Albemarle | 975-9300 | 974-4335 |
| Mountain View | 293-7455 | 293-2067 |  | Monticello | 244-3100 | 244-3104 |
| Murray | 977-4599 | 979-5416 |  | Western Albemarle | 823-8700 | 823-8711 |
| Red Hill | 293-5332 | 293-7300 |  | Community Lab School | 296-3090 | 979-6479 |
| Scottsville | 286-2441 | 286-2442 |  | Center for Learning & Growth | 974-8070 | 979-6479 |
| Stone-Robinson | 296-3754 | 296-7645 |  | Center I | 244-8900 | 872-4570 |

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_)

the following medication: (check one) (name of child)

\_\_\_\_\_ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_

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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)