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 286-4040
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 school staff to administer the medication. Please print.

Please have the school nurse, or a member of school staff, administer to: ________________________________ (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.** 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: __________________________

_____________________________      __________________
Signature of Physician/Date          Name of Parent          Home Telephone
(for prescription medication)

_____________________________      __________________
Physician telephone               Signature of Parent or Guardian/Date
(for prescription medication)      (for all medication)
(for all medication)