

# Medication Authorization for Prescription and Non-prescription Medications



**Section A** - Completed by the parent/guardian for ALL medication authorizations – one form per medication.

**Section A & B** - Completed for any long-term medication (*those lasting longer than 10 working days*) authorizations or for any medications required to be on hand daily for life threatening emergencies (*ie., epinephrine/ albuterol*). Section B is to be completed/signed by physician.

- The parent must bring the medication to the school office. Medications are not to be left in the classroom, on the teacher’s desk, in the student’s lunch box, locker or in a backpack.
- One form (front and back) needs to be completed for EACH medication left at the school.
- The medication must be in the original container/packaging, including the pharmacist/manufacturer’s administration instructions and dosage device (cup, chamber, etc).
- Children’s anti-histamine must be in the unopened original container.
- **The medication must be accompanied by this completed and signed form.**

**Section A: To be completed by parent/guardian** (must be completed by the parent/guardian for ALL medication authorizations)

Medication authorization for: \_\_\_\_\_ Medical Condition: \_\_\_\_\_

(Child’s name)

Linton Hall School has my permission to administer the following medication:

Medication name: \_\_\_\_\_

Medication Expiration Date: \_\_\_\_\_ (*must have current expiration date*)

Dosage and times medication is to be administered: \_\_\_\_\_

Special instructions (if any): \_\_\_\_\_

This authorization is effective for the \_\_\_\_\_ school year or \_\_\_\_\_ to \_\_\_\_\_.  
(Start date) (End date)

Parent’s or Guardian’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section B: The child’s physician must sign this form for any long-term medication authorizations** (*those lasting longer than 10 working days*) or for any medications required to be on hand daily for life threatening emergencies (*ie., epinephrine/ albuterol*)

I, \_\_\_\_\_ certify that it is medically necessary for the medication(s) listed above in

(Name of Physician)

Section A to be administered to: \_\_\_\_\_ for a duration that exceeds 10 work days.

(Child’s name)

Special instructions (if any): \_\_\_\_\_

Physician’s Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

# Medication Authorization for Prescription and Non-prescription Medications

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Class: \_\_\_\_\_

1. Parent: \_\_\_\_\_ Phone Number: 1. \_\_\_\_\_ 2. \_\_\_\_\_  
Parent: \_\_\_\_\_ Phone Number: 1. \_\_\_\_\_ 2. \_\_\_\_\_
2. Emergency Contacts:  
Name/Relationship Telephone Numbers
- a. \_\_\_\_\_ 1. \_\_\_\_\_ 2. \_\_\_\_\_  
b. \_\_\_\_\_ 1. \_\_\_\_\_ 2. \_\_\_\_\_
3. Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_

## Parent/guardian request for administration of medication

Schools must obtain specific written parental/guardian authorization before any medical treatment including medication administration can be provided. When signed by the parent/guardian this written informed consent gives trained school staff authorization to implement the medical order. When parents/guardians authorize a medical treatment for their child in school such authorization includes permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment ordered. Health treatment plans not signed and dated by the parent/guardian will not be implemented until all signatures have been obtained. Legally appropriate school health professional-medical prescriber communications based on the medical orders generally include the following:

- The prescription of treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions);
- Implementation of the treatment in school (e.g., questions regarding safety concerns, infection control, issues, or modifications in the treatment order related to the school setting or student's academic schedule); and
- Student outcomes from the treatment (e.g., questions regarding observed side effects, possibly untoward reactions, observation of behavior in the classroom).

**Student may not attend school until the written parental/guardian authorization has been signed and returned to the school.** In accordance with the Virginia Code § 22.1-274, I agree to the following:

I will not hold the School Board or any of its employees liable for any negative outcome resulting from the self-administration of said emergency medication by the student.

### Release of Liability / Hold Harmless

In consideration of Linton Hall School administering the above requested medication to my child \_\_\_\_\_, I hereby acknowledge that the school, its faculty and staff are not responsible for reactions to the medication, an improper dosage in the medication, etc., and will only be responsible for injuries relating to negligent physical administration of the medication.

I understand that the person administering this medication or treatment may or may not be trained or experienced in the administration of medications or treatments. I knowingly consent to these procedures and request that the medication/treatment be administered.

Print Parent's/Guardian's Name Date \_\_\_\_\_

Parent's/Guardian's Signature Date \_\_\_\_\_