FAUQUIER COUNTY PUBLIC SCHOOLS 7-5.3F1
AUTHORIZATION FOR MEDICATION ADMINISTRATION

Parent/Guardian Section

Student: DOB: Age: Grade:

School: Teacher:

Allergies: ***NOTE – Student MUST have taken medicine at least once before getting it at school***

Parent/Guardian Signature: Date:

Parent/Guardian Printed Name:

Signature gives permission for principal's designee to administer prescribed medicine and to contact the provider if necessary. Over-the-Counter (OTC) medicine, parent's signature gives principal's designee permission to administer medicine.

Provider Section

Medication Name:

Dose: Frequency: Length of Time:

Time to give: Give on Half Days? ☐ Yes ☐ No ☐ N/A

RX Reason (Unless Confidential):

Provider Signature: Date:

Provider Printed Name:

Provider Phone: Fax:

Provider Address:

Required for all prescription medicines and OTC medicines that exceed manufacturer's recommended dose. Must be in original pharmacy labeled container.

Parent/Guardian Over the Counter (OTC) Medication Permission

Medication Name	How much?(dose)	How often?	Med. expiration	Reason /additional instructions
1.				
2.				
3.				

Must be in original, unopened container. Cannot be administered daily for more than 10 consecutive school days without a provider prescription.

Staff Use Only: Received by: **Date:**

Doses submitted 1: 2: 3: Entered in Infinite Campus Date: