ALEXANDRIA CITY PUBLIC SCHOOLS
AUTHORIZATION TO ADMINISTER MEDICATIONS FOR GRADES 9-12

Name of student: ____ Grade: __________
School Year: ______________ Name of School: ____________________________________
Birth Date: ____________________

NOTE TO PARENT/GUARDIANS:

We attempt to discourage administration of medication during school hours. We request that whenever possible, medication be scheduled during non-school hours. Information shall be shared with staff on a "need to know" basis.

The Alexandria City Public Schools require that all students who need medication during school hours must do the following:

1. All medication shall be delivered by the parent/guardian to the school nurse.
2. A written consent form signed by the parent or legal guardian is required before medication can be given.
3. All medications except those noted in #5 and #6 must have signed physician authorization to the school nurse BEFORE medication can be given.
4. Prescription medication must be in a container appropriately labeled and dated by the pharmacist.
5. Grades 9-12: Non-prescription medication will be given or carried only with written parental permission, stating medication, dosage and frequency. Liquid medication will be kept in the school health office; students may carry a one day supply of capsule or tablet medications. Written parental permission is valid for the current school year, and must be signed and dated by the school nurse who keeps the original completed form and gives a copy for the student to carry.
6. Prescribed antibiotics to be given for up to fourteen days will not require a physician's note, but need to be properly labeled in a pharmacy container that can remain in the school. Ask the pharmacist to prepare an additional labeled bottle for the school.
7. Epinephrine auto-injectors, inhalers and/or injectable medications require a separate authorization form.
8. When medication must be administered during a field trip or other off-campus school activity, the medication shall be transported by the staff member designated to administer the medication.

PHYSICIAN/LICENSED PRESCRIBER: PLEASE COMPLETE AND SIGN THIS SECTION FOR PRESCRIPTION MEDICATIONS

Student Name___________________________________ Date_______________________________

Name of Medication (no abbreviations) ____

Dosage at School____Frequency _____________

Reason for Medication____

Possible Side Effects____

Other medication currently being taken ____

Physician/Licensed Prescriber's Name: ____
(Signature) (Printed/Stamped)

Telephone number __________________________________

PARENT GUARDIAN: PLEASE COMPLETE THIS SECTION FOR ALL MEDICATIONS

I, the parent/guardian of _________________________________request that the school nurse or, in her absence, the principal or principal's designee, be caretaker of and administer the following medication(s) to my son/daughter: Tylenol or Motrin or ___________________________. I have given the first dose of this medication at home. I release the Alexandria City Schools from the responsibility of any adverse effects of this medication(s). Other medications currently being taken are: ____.

Name (print) _________________________ Signature____

Telephone # at home____________________ Telephone # at work_______________________________ 4/08