DINWIDDIE COUNTY PUBLIC SCHOOLS
DEEP ROOTS • GREAT HEIGHTS

AUTHORIZATION FOR MEDICATION
Prescription or Over-the-Counter Medication

(TO BE COMPLETED BY PHYSICIAN)

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____
School: _____ **Phone #:** _____ **Fax#:** _____
Allergies: _____
Diagnosis: _____

MEDICATION	DOSAGE & ROUTE	FREQUENCY	SPECIFIC TIMES	SPECIAL INSTRUCTIONS/ SIDE EFFECTS

List any emergency precautions / health emergencies that should be anticipated for this student; e.g. allergy triggers, diabetic reactions, etc.): _____

_____

There are no extraordinary emergency medical services available at school. Since only CPR and first aid are available until 911 arrive, is this adequate for student survival? ☐ YES ☐ NO, If **"NO",** specify: _____

_____

_____

Physician's Name: _____ **Phone#:** _____ **Fax #:** _____

Physician's Office
Address: _____

_____ _____
Physician's Signature **Date Completed**

****

The information below will be obtained by School Board District Personnel

PARENTAL PERMISSION FOR MEDICATION

(TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN)

Student's Name:_____ **Date of Birth:** _____ **Grade:** _____

I grant the principal or his/her designee the permission to assist or perform the administration of each medication to or for my child during the school day, including when he/she is away from school property for official school events. If my child has been authorized by his/her physician to self-administer their medication(s), I grant permission for my child to self-administer their medication at school and when they are away from school property for official school events. In the event that my child is unable to self-administer their medication, I give permission for the principal/designee to perform the administration of the prescribed medication.

NOTE:

- **Medications must be supplied in the original container.** Ask the pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.
- School personnel may only administer medications authorized by a physician.
- It is your responsibility to notify the school when there is a change in medication regimen.

Parent / Guardian Name (Printed): _____

Home Phone #: _____ **Cell Phone #:** _____ **Work Phone#:**_____
(include Ext. if any)

_____ _____
Parent / Guardian Signature **Date**