Form 906N
Revised 12/13

Botetourt County Public Schools

Physician's Request and Parent Permission for Administration of Medication

Administration of medications will be permitted on school property only when medically necessary and with appropriate documentation. For the safety of our students, the following guidelines must be followed:

1. Written parent/guardian permission is required to administer any medication at school.
2. **Over-the-counter (OTC) medications** must be delivered by the parent/guardian to the school in the original container.
3. This form must be completed by the parent in order for the school nurse or trained health aide to administer **OTC medications** that you send to school**.** A physician's signature is only required when an **OTC medication** is administered for longer than 5 consecutive days, if **OTC medication** is required to be administered outside the manufacturer's label directions, or if your child requires the **OTC medication** on a regular basis.
4. **Prescription medications** are to be brought to the school by the parent/guardian in the original container labeled by the pharmacist with the name of the student, the name of the medication, dosage, name of the physician, and time to be given.
5. A written request using this form from a physician/practitioner detailing the **prescription medication** and the specific information below is required before administering a dose at school.
6. Any change of prescriptions requires a new written order from the prescriber. School Nurses can facilitate communication with the physician as needed.

Note: For those students requiring emergency plans (Allergy Action Plan, Asthma Action Plan, Seizure Action Plan, and/or Diabetic Management Plan), the school nurse will identify / train school personnel on those emergency plans to ensure continuity of care in the school setting, including field trips.

SECTION I: TO BE COMPLETED BY THE PARENT / GUARDIAN

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

Address _____

I hereby request that my child be given the medication named below while in school and away from school for official school-related activities. I understand that the medication will be given by the school nurse or trained health aide. I give permission for the appropriate personnel to communicate with my child's physician in matters related to medication and health supervision. I understand and agree that the Botetourt County School Board, its officers, agents, and employees are not responsible for the effects of the medication administered.

I understand that I must notify the school of any changes in my child's condition, medication, or dosage. I further understand that I am responsible for ensuring the medication safely arrives at school and for getting refills of the medication as indicated.

I do _____ do not _____ request that the designated school personnel give the above medication on school days of early dismissal / late schedule.

Parent / Guardian Name (Print) _____ **Daytime Phone No.** _____

Parent / Guardian Signature _____ **Date** _____

SECTION II: TO BE COMPLETED BY PHYSICIAN/PRACTITIONER FOR PRESCRIPTION MEDICATIONS AND A PARENT FOR OTC MEDICATIONS

Name of Medication _____ **Dose** _____

Time of Administration _____

Reason for Medication Administration _____

Beginning Date for Administration _____ **Ending Date** _____

Possible Side Effect / Special Instructions or Precautions _____

_____

Physician's/ Practitioner's Signature _____ **Date**_____
(required for prescription meds / special circumstances for OTC meds) **Phone No** _____