King George County Schools
Medication-Treatment Request
School Year: _____

King George County School Board policy JHCD requires this form to be on file prior to any student receiving medication or prescribed treatments. This is required for all medications, prescription and over the counter, and treatments to include the use of crutches, wheelchairs and other durable medical equipment. Alternative medications and treatments not approved by the US Food and Drug Administration for safety and effectiveness will not be administered in school.

1. Parent/Guardian or authorized adult must bring in all medications to the school clinic. Students may not deliver medications, to do so is in violation of the Student Code of Conduct.
2. Medications must be verified, counted and documented by the school nurse or designee.
3. All prescription medication must be in the original prescription bottle with pharmacist's label attached.
4. Over-the-counter (OTC) medication must be in the unopened original container with the manufacturer's dosage label and safety seal intact.
5. The first day's dose of any new non-emergency medication must be given at home before it can be administered at school.
6. Parent/Guardian is responsible for collecting any unused portion of a medication prior to the end of the school year, any unclaimed medication will be destroyed.

PRESCRIBED MEDICATION/ TREATMENT AUTHORIZATION- To be completed by prescribing healthcare provider

Name of Child: _____ DOB: _____

Reason for medication/ treatment: _____

Name of medication/ treatment: _____

Dosage: _____ Time(s) to be given at school: _____ Route: _____

Duration: _____ Side effects: _____

If PRN, specify when indicated (signs/symptoms): _____

Frequency of administration (ranges not accepted, i.e. every 2-4 hours): _____

I certify that, in my opinion, it is medically necessary that the medication/ treatment described above be administered to the named student during school hours and is to be administered by the school nurse or authorized personnel.

Authorized Prescriber's Name (print): _____ Phone _____

Authorized Prescriber's Signature: _____ Date: _____

OVER-THE-COUNTER MEDICATION/ TREATMENT AUTHORIZATION- To be completed by parent/ guardian

Name of Child: _____ DOB: _____

Reason for medication/ treatment: _____

Name of medication/ treatment: _____

Dosage: _____ Route: _____ Duration: _____

Frequency of administration (ranges not accepted, i.e. every 2-4 hours): _____

TO BE COMPLETED BY PARENT/ GUARDIAN

I am unable to administer the above medication or treatment to my child. I request and authorize school personnel to administer the above treatment as ordered. If for any reason the treatment requested or any portion thereof is not administered as requested, I hereby release the school board and its officers and agents from any responsibility or liability arising therefrom. I give permission for school personnel to contact the Authorized Prescriber regarding the administration of the medication/ treatment.

Parent/ Guardian Name (print): _____ Phone _____

Parent/ Guardian Signature: _____ Date: _____

TO BE COMPLETED BY THE SCHOOL NURSE OR AUTHORIZED DESIGNEE- Attach documentation if applicable

Check as appropriate:

- ☐ Prescription medication section is complete, including signature of authorized prescriber. Authorization acceptable on prescription form/ office form.
- ☐ Over-the-counter section is complete, including signature of parent/ guardian.
- ☐ Prescribed medication is properly labeled by pharmacist and is consistent with prescriber's order.
- ☐ OTC medication is in an original, sealed container with manufacturer's label present.

Signature, School Nurse or Authorized Designee: _____ Date: _____

Medication Inventory List

Medication	Quantity	Drop Off- Signatures/ Date	Pick Up- Signatures/ Date
		Drop off by: Received by: Date:	Received by: Received from: Date:
		Drop off by: Received by: Date:	Received by: Received from: Date:
		Drop off by: Received by: Date:	Received by: Received from: Date:
		Drop off by: Received by: Date:	Received by: Received from: Date:
		Drop off by: Received by: Date:	Received by: Received from: Date:
		Drop off by: Received by: Date:	Received by: Received from: Date:
		Drop off by: Received by: Date:	Received by: Received from: Date:
		Drop off by: Received by: Date:	Received by: Received from: Date:
		Drop off by: Received by: Date:	Received by: Received from: Date:
		Drop off by: Received by: Date:	Received by: Received from: Date: