

**Chesterfield County Public Schools  
MEDICATION REQUEST FORM  
PRESCRIPTION MEDICATION**

**TO BE COMPLETED BY PARENT/GUARDIAN: (PLEASE PRINT)**

<b>Student Name:</b> _____			
Last	First	Middle Initial	
<b>Date of Birth:</b> _____	<b>Grade:</b> _____	<b>School:</b> _____	
<b>Student ID Number :</b> _____	<b>Teacher:</b> _____		
<p>I request that the medication below be administered to my child by authorized and trained school personnel. I agree to furnish this medication and replenish the supply as needed, in the original container with the label intact. I understand and accept that the Chesterfield County School Board, its employees, agents, or designees are not responsible for any effects of the medication administered when it is administered according to best practice guidelines and standards. I also agree to pick up any unused medication from the school clinic at the end of the school year. I understand that medication not picked up by parent or guardian at the end of the school year will be discarded.</p>			
_____	_____	_____	_____
<b>Parent/Guardian (Print Name)</b>	<b>Parent/Guardian Signature</b>	<b>Date</b>	<b>Phone Number</b>

The school nurse has the authority to contact the student's licensed healthcare provider to clarify any medication order.

**TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER (Physician, Physician Assistant, Nurse Practitioner):**

<small>PER CCPS SCHOOL BOARD POLICY 4130R, AUTHORIZATION OF A LICENSED HEALTHCARE PROVIDER (LHP) IS REQUIRED FOR PRESCRIPTION MEDICATIONS OR OVER THE COUNTER MEDICATIONS GIVEN MORE THAN THREE TIMES PER MONTH.</small>	
<b>Medication:</b> _____	
<b>Reason Medication is needed:</b> _____	
<b>Dosage, Time and Route:</b> _____	
<b>Possible Side Effects:</b> _____	
<b>Special Handling Instructions:</b> _____	
<b>Beginning Date:</b> _____	<b>Ending Date:</b> <input type="checkbox"/> End of School Year <input type="checkbox"/> Other _____
<b>Prescriber Signature</b> _____	<b>Date</b> _____
<b>Prescriber PRINTED Name</b> _____	<b>Phone</b> _____ <b>Fax</b> _____

**FOR STUDENTS WITH DIABETES, ASTHMA AND/OR A LIFE-THREATENING ALLERGY (ANAPHYLAXIS):** With parental consent and written approval from student's health care provider, student may carry and use inhaled asthma medication, auto-injectable epinephrine, or diabetes supplies and self-check blood glucose levels. Refer to Individualized Healthcare Plan/Diabetes Medical Management Plan. (Refer to CCPS School Board Policy 4130)

<b>Medication received by</b> _____	School Staff Member Name/Signature	on _____	Date
<b>Medication expiration date</b> _____			
<b>Medication returned to parent/guardian by</b> _____	School Staff Member Name/Signature	on _____	Date
<b>Parent/Guardian picking up medication</b> _____	Parent/Guardian Name/Signature	on _____	Date

**Chesterfield County Public Schools**  
**STUDENT MEDICATION RECORD**  
**SCHOOL YEAR: 2018-2019**

KEY:		
X: Not a school day	W: Withheld	S: Self-Administered
N: No show to clinic	F: Field Trip	I: Inclement weather
O: Out of medication	A: Absent	R: Refused
E: Early Dismissal		

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Expiration date of Medication: \_\_\_\_\_ Dosage, Route, Time: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

- Instructions: 1. Record time medication is given and initials of staff member administering medication. For medication prescribed for use **EVERY DAY**, an entry is required in each box. (See KEY below)  
 2. Record initials and signature of staff member administering medication at bottom of form  
 3. File form in student's educational record at the end of each school year.

**FOR SCHOOL STAFF USE ONLY**

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Sept.																															
Oct.																															
Nov.																															
Dec.																															
Jan.																															
Feb.																															
March																															
April																															
May																															
June																															

**School Staff Administering Medication:**  
 Initials and signature: \_\_\_\_\_  
 Initials and signature: \_\_\_\_\_  
 Initials and signature: \_\_\_\_\_  
 Initials and signature: \_\_\_\_\_

**Comments:**