Chesterfield County Public Schools
MEDICATION REQUEST FORM
PRESCRIPTION MEDICATION

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

Student Name:_____
Last **First** **Middle Initial**

Date of Birth: _____ **Grade:** _____ **School:** _____

Student ID Number : _____ **Teacher:** _____

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.

_____ _____ _____ _____
Parent/Guardian (Print Name) **Parent/Guardian Signature** **Date** **Phone Number**

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):

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.

Medication: _____

Reason Medication is needed: _____

Dosage, Time and Route: _____

Possible Side Effects: _____

Special Handling Instructions:_____

Beginning Date: _____ **Ending Date:** ☐ **End of School Year** ☐ **Other** _____

Prescriber Signature_____ **Date** _____

Prescriber PRINTED Name _____ ***Phone*** _____***Fax*** _____

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)

Medication received by _____ on _____
School Staff Member Name/Signature **Date**

Medication expiration date _____

Medication returned to parent/guardian by _____ on _____
School Staff Member Name/Signature **Date**

Parent/Guardian picking up medication_____ on_____
Parent/Guardian Name/Signature **Date**

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		

FORM AAA-1075
Revised 3/2019

Chesterfield County Public Schools
STUDENT MEDICATION RECORD
SCHOOL YEAR: 2019-2020

Student Name_____ Grade _____Date of Birth_____
Last **First**

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: