

Chesterfield County Public Schools
MEDICATION REQUEST FORM
OVER THE COUNTER

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

Student Name: _____			
Last	First	Middle Initial	
Date of Birth: _____	Grade: _____	School: _____	
Student ID Number : _____		Teacher: _____	
<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>			
_____	_____	_____	_____
Parent/Guardian (Print Name)	Parent/Guardian Signature	Date	Phone Number

Non-prescription (over the counter) medication will not be administered to a student more than twice a day, for more than three consecutive days, or more than three times monthly without the written authorization of the student's physician, physician's assistant or nurse practitioner. (Refer to CCPS School Board Policy 4130R)

Medication: _____
Reason medication is needed: _____
Dose: _____
(Dose may not exceed the manufacturer's recommendations without written authorization from the student's licensed healthcare provider)
Route: <input type="checkbox"/> By mouth <input type="checkbox"/> Topical/skin <input type="checkbox"/> Eye <input type="checkbox"/> Ear <input type="checkbox"/> Nose <input type="checkbox"/> Other _____
Time: _____
Begin Date: _____ End Date: <input type="checkbox"/> End of School Year <input type="checkbox"/> Other _____

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

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

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: _____ Last _____ First _____ 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: