

**Chesterfield County Public Schools**  
**MEDICATION REQUEST FORM**  
**OVER THE COUNTER**

**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>

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)

<b>Medication:</b> _____
<b>Reason medication is needed:</b> _____ <b>ICD-10:</b> _____
<b>Dose:</b> _____
<small>(Dose may not exceed the manufacturer's recommendations without written authorization from the student's licensed healthcare provider)</small>
<b>Route:</b> <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 _____
<b>Time:</b> _____
<b>Begin Date:</b> _____ <b>End Date:</b> <input type="checkbox"/> End of School Year <input type="checkbox"/> Other _____

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

**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

**Chesterfield County Public Schools**  
**STUDENT MEDICATION RECORD**  
 SCHOOL YEAR: \_\_\_\_\_

Student Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ 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
July																															
Aug.																															
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:**