

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: _____	ICD-10: _____
Dosage, Time and Route: _____	
Possible Side Effects: _____	
Special Handling Instructions: _____	
Beginning Date: _____	Ending Date: ☐ End of School Year ☐ Other _____
Prescriber Signature _____	NPI: _____ 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 _____	School Staff Member Name/Signature	on _____	Date
Medication expiration date _____			
Medication returned to parent/guardian by _____	School Staff Member Name/Signature	on _____	Date
Parent/Guardian picking up medication _____	Parent/Guardian Name/Signature	on _____	Date

Chesterfield County Public Schools

STUDENT MEDICATION RECORD

SCHOOL YEAR: _____

Student Name _____ Grade _____ Date of Birth _____

Name of Medication: _____ Expiration date of Medication: _____ Dosage, Route, Time: _____

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

[illegible]

School Staff Administering Medication:

Initials and signature: _____

Initials and signature: _____

Initials and signature: _____

Initials and signature: _____

Comments: