Attachment I
Regulation 757-4

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Part I - Parent or Legal Guardian to Complete - One Medication per Form

Student Name (Last, First, Middle)	Allergies

Date of Birth	School Name	School/SACC Year	Grade	Teacher

Has student taken this medication before? ☐Yes ☐No (If no, the first full dose must be given at home.)

First dose was given: Date _____Time_____

I/We hereby request Prince William County Public School personnel/CCC to administer medication as directed by this authorization. I/We authorize school personnel/CCC to communicate with the health care provider regarding the administration of this medication as allowed by HIPPA. I/We are aware that non-medical personnel may be administering medication to our child. I/We hereby release the Prince William County Public School Division and all of its employees/CCC of and from any and all liability in law for damages either we or our child may incur as a result of this request.

_____ _____ _____
Parent or Guardian Signature | Daytime Telephone | Date

Part II - Physician must complete this section for all prescription medication or for any nonprescription medication that is to be given for more than the recommended duration or dosage, or when age guidelines are not followed as written on the label. Nonprescription medication to be given for relief of symptoms as directed on the package label may be given with the parent or guardian's signature, and does not require a physician's authorization and signature.

Any necessary medication that possibly can be taken before or after school/SACC should be so prescribed. Information should be written in lay language with no abbreviations.

Student's Diagnosis:	ICD-9 Code: (when applicable)

Name of Medication:

Dosage of Medication:	Route:	Time(s) or interval between times to be given:

If medication is to be given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time at which it may be given again.

Effective date: ☐Current School/SACC Year _____ Or ☐From _____ To _____	Medication expires on:

_____ _____ _____ _____
Physician Name (Print) | Physician Signature | Telephone | Date

_____ _____ _____ _____
Parent or Guardian Name (Print) | Parent or Guardian Signature | Telephone | Date

Parent Information Regarding Medication Procedures

The parent or guardian must transport medications to and from school/SACC. All prescription medications, including physician prescription drug samples, must be in their original containers and labeled by a physician or pharmacist. Over-the-counter medication must be in the original, sealed container. No medication will be accepted by school personnel/CCC without receipt of completed and appropriate medication forms.

Within one week after expiration of the effective date on the physician order, or on the last day of school/SACC, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.

A physician may use office stationery or a prescription pad in lieu of completing Part II. Faxed authorization may be acceptable as long as there is a signed parental consent. Any changes in the original medication authorization will require a new written authorization and a corresponding change in the prescription label.

Attachment VI
Regulation 757-4

Medication Permission Form
For Extended Day/Overnight Field Trips
(One form for each medication)

Any medication that must be administered during an overnight field trip, either over-the-counter or prescribed requires a physician's written order and a parent/guardian authorization. A signed permission form is necessary for all of the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc. Only FDA approved medicines will be accepted. The required medications shall come in the original container with proper labeling. Over-the-counter medications shall come in the original sealed container. This permission form is valid for the current field trip only. Medications may only be given by Prince William County Public Schools (PWCS) employees unless an accompanying parent administers it to their own child.

I hereby certify that it is necessary for _____ DOB:_____
(Student's Full Name)

Teacher/Homeroom: _____ Grade: _____ School:_____
to be administered the medication listed below when she/he is away from school property on an approved school field trip.

Name of Medication:_____

Reason for Medication (Diagnosis):_____

Dosage to be Given:_____Route (Mouth, Injection, Etc.):_____

Time(s) of Administration: _____Allergies: _____

Beginning Date: _____ Ending Date:_____ Amount of Liquid or Count of Pills: _____

Physician's Signature: _____ Date: _____

Emergency Telephone Numbers:

Parent/Guardian: _____H:_____W:_____C:_____

Parent/Guardian: _____H:_____W:_____C:_____

Doctor's Name: _____Phone:_____

Parents are requested to pick up any leftover medication at the end of the field trip. Medications that are left after this time will be discarded.

(continued on back)

I hereby consent to protected health information being used and disclosed to carry out treatment or health care of my child. I understand that PWCS may need to give and receive protected health information pertaining to the management of my child's medical condition with the health care provider listed above, and I hereby authorize the exchange of this information as needed to carry out the treatment or health care of my child. I also give permission for the information on this form to be reviewed and utilized by staff of this school and any school health personnel providing school health services in the School Division for the limited purpose of meeting my child's health and educational needs.

I hereby authorize PWCS employees to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his or her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration specific to this field trip, may assist my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on this record.

I/We hereby release PWCS and all of its employees of and from any and all liability in law for damages either we or our child may incur as a result of this request.

Signature of Parent/Legal Guardian_____Date:_____