SURRY COUNTY SCHOOLS
SCHOOL HEALTH PROGRAM
Request For Medication to be Given During School Hours

Location of Medication ____

Medication Expiration Date____

Amount Received____

Note to Parents/Guardians:

The Surry County Schools require that all students who need medication during school hours must:

1. Present this completed form
2. Prescription medicines must be brought to school by an adult in a pharmacy- labeled bottle which contains instructions on how and when the medicine is to be given. (Parents may request the pharmacist dispense two bottles of medication, one for home and one for school.)
3. Over-the counter drugs must be received in the original container and will be administered according to the doctor's written instructions.

Medication may be given by school personnel provided the physician completes this medication permission request form. Medication should be brought to school by parents rather than children.

Name of student ______________________________School___________Teacher__________

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To Be Completed by Physician/Only one medication per medication sheet

Medication___________________________________Dosage___________________________

Time(s) to be given at school __________________________Length of time ________________

Circle form of medication: Tablet Capsule Liquid Ointment Inhalant Other _______________

Emergency Medications (**ONLY** Inhalers, Epi Pens, and Glucagon) may be kept on student

yes________ no________

Precautions/Side Effects/Comments____

Physician's Signature______________________________________Date__________________

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Parent's Permission

I give my permission for my child to receive medication during school hours as prescribed by a physician. I hereby release the School Board, their agents, and employees from any and all liability that may result from my child taking the prescribed medication. I understand that any discontinued or unused medication will be disposed of at the end of the school year. If a Care Plan is needed for my child, I will be asked to complete one. If the Care Plan is not returned completed, the nurse may complete one and give to staff on a need to know basis.

Parent Signature _________________________ Date____________Telephone #____________

School Use Only Reviewed by: School Nurse_______________________________

RETURN TO SCHOOL NURSE

Student _____

Medication _____

Time To Be Given _____

MEDICATION LOG

School Year _____

Dosage _____

Teacher _____

Capsule, Tab., Liq., Inhaler

MTH.	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
AUG.																															
SEPT.																															
OCT.																															
NOV.																															
DEC.																															
JAN.																															
FEB.																															
MAR.																															
APR.																															
MAY																															
JUN.																															

Codes(Chart Reason)

D/C=Med. Discontinued

R=Refused

AB=Absent

NMS=No Medication at School

Initials _____ Name _____

Initials _____ Name _____