

School Name: \_\_\_\_\_

**MEDICATION REQUEST FORM**

THE SCHOOL ASSUMES NO RESPONSIBILITY FOR NON-MEDICALLY PRESCRIBED MEDICATION OR MEDICATION ADMINISTERED BY THE PUPIL HIMSELF

No medication will be administered unless

1. There is a Medication Request Form signed by a Physician/Nurse Practitioner yearly or when there is a medication change.
2. This form is signed by the parent and principal/designee of the school.
3. The medication is presented by the parent/guardian to the school nurse, principal or designee.
4. The medication is in the original container.

**STATEMENT OF PHYSICIAN/NURSE PRACTITIONER TO BE COMPLETED BY Physician/Nurse Practitioner**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

School: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medication/Treatment Required: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time/Schedule : \_\_\_\_\_

Side effects, precautions, special instructions or comments: \_\_\_\_\_

I have examined the above child and determine that the above medication is medically necessary during school hours.

Physician/Nurse Practitioner Name (*Please Print*): Pam Mancini MD, Nimali Fernando MD

Address: 321 Park Hill Drive Fredericksburg, VA 22401

Telephone: (540 ) 361-1800 Fax: (540 ) 361-1803

Physician/Nurse Practitioner Signature: \_\_\_\_\_

**STATEMENT OF PARENT/GUARDIAN TO BE COMPLETED BY Parent/Guardian**

I am unable to personally administer the above medication to my child and no member of my family or relative is able to do so. I request, and hereby authorize, the school to administer the above medication as prescribed. I consent to the exchange of information between the physician/nurse practitioner with the school nurse regarding the medication and treatment.

\_\_\_\_\_  
*Signature of Parent/Guardian*                      *Date*

\_\_\_\_\_  
*Home Telephone #*

\_\_\_\_\_  
*Work Telephone #*

\_\_\_\_\_  
*Cell phone #*

\_\_\_\_\_  
*Principal/Designee Signature*

\_\_\_\_\_  
*Date*