HENRY COUNTY PUBLIC SCHOOLS
Heritage · Purpose · Passion · Possibilities

P.O. Box 8958
3300 Kings Mountain Road
Collinsville, VA 24078
Phone: (276) 634-4700
Fax: (276) 638-2928

Parental Consent for Administering Medication

Student's Last Name: _____ First Name: _____ M.I. _____

Student Number _____ Grade _____ Date of Birth: _____ | ___ | ___

Allergies: _____

Parental Consent

I am the parent or guardian of _____. I give my permission for him/her to take the following prescribed medication while in Henry County Public Schools. I hereby acknowledge that I have read and I understand the School Board Regulations relating to the taking of medications. I hereby release Henry County Public Schools and its employees from any claims or liability connected with its reliance on this permission and agrees to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the above licensed prescriber.

_____ _____ _____

Parent/Guardian Signature Daytime Phone Date

Medication Authorization
(For Use by Licensed Prescriber ONLY)

Relevant Diagnosis _____ Medication _____

Dates medication must be administered at school:
_____ Short Term (List dates to be given): _____
_____ Every Day at school
_____ Episodic/Emergency Events ONLY

Dosage (Amount): _____ Route: _____ Form: _____ Time(s) of Day: _____

A. Serious reactions can occur if the medication is not given as prescribed: YES _____ NO _____
If yes, describe: _____
_____

B. Serious reactions/adverse side effects from this medication may occur: YES_____ NO _____
If yes, describe: _____
_____

Action/Treatment for reactions: _____
Report to you: ___YES ____ NO (Drug information sheet may be attached.)

Special Handling Instructions: ____ Refrigeration ___ Keep out of sunlight ____ Other

_____ _____

Asthmatic/Diabetic ONLY

This student is both capable and responsible for self-administering this medication:

____ NO ____YES—Supervised ____ YES—Unsupervised

This student may carry this medication: ____NO ____ YES

Licensed Prescriber's Name _____
Telephone Number_____ Emergency Number _____
Licensed Prescriber's Signature _____ Date _____