MECKLENBURG
COUNTY PUBLIC SCHOOLS

Kelly Burns, RN MCPS Nurse Supervisor
175 Mayfield Drive, Boydton, VA 23917
Phone: 434-738-6111 Extension: 2101
kburns@mcpsweb.org

Healthcare Provider Authorization/Parental Consent for Administering Medication

(Use a separate authorization form for each medication.)

Student's LAST Name _____, First Name _____, M.I. _____
Student I.D. Number _____ Grade _____ Date of Birth _____/_____/_____
Allergies _____

Parental Consent

I am the parent or guardian of _____. I give my permission for him/her to take/receive the listed prescribed medication: _____ while in school. I understand the medication may be
(Name of medication)
administered by the principal, school nurse, or a non-medical staff member who has received training in medication administration. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medications. I hereby release Mecklenburg County Schools and its employees from any claims or liabilities connected with its reliance on this permission and agree 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 ☐ Yes ☐ No
(May use "entire school year" or list dates) (Please check)

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

A. Serious reactions can occur if the medication is not given as prescribed: ☐ Yes ☐ No (Please check)
If yes, describe: (Drug information sheet may be attached.)

B. Serious reactions/adverse side effects from this medication may occur: ☐ Yes ☐ No (Please check)
If yes, describe: (Drug information sheet may be attached.)

C. Action/Treatment for reactions: _____
Report to you: ☐ Yes ☐ No

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
☐ Yes ☐ No This student may carry this medication

Licensed Prescriber's Name _____

Telephone Number _____ Emergency Number _____

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