MEDICATION PERMISSION FORM

Date Received	Medication Name	Quantity Received	Received from	Exp. Date	Nurse initials

Initial: **entered in Welligent _____ Scanned into Welligent _____**
Nurse signature _____ Date_____

Notes:

Medication count- Dates:

Aug. _____ Sept._____ Oct._____ Nov._____ Dec. _____
Jan._____ Feb._____ March _____ April_____ May_____
June_____ July._____

**** Must Document in Welligent**

TO BE COMPLETED BY PHYSICIAN

I certify that, in my opinion, it is medically necessary that the medication described below be administered to _____ _____during school hours and that this medication may be administered by school personnel.

Prescription:

Medication _____

Dosage & Time _____

Duration _____

Date of Prescription _____

Diagnosis requiring medication _____

Date _____ _____
Signature of Physician

Phone#_____ _____
Printed Physician signature

TO BE COMPLETED BY PARENT/LEGAL CUSTODIAN

I, _____, the parent or legal custodian of _____request that the clinic attendant, school nurse or principal's designees administer the above medication to the above named student during the school hours and at the times indicated. I agree to furnish said medication in the **ORIGINAL** container supplied by the pharmacy with the label intact. I understand and accept that the Henrico County School Board, its employees, agents or designees are not responsible for any effects of the medication administered.

Date _____ _____
Signature of Parent/Legal Custodian
Home Tel. No. _____
Work Tel. No. _____

NOTE: PLEASE RETURN THIS FORM WITH MEDICATION OR HAVE YOUR PHYSICIAN MAIL OR FAX IT BACK TO YOUR CHILD'S SCHOOL, ATTN: SCHOOL NURSE