COLONIAL HEIGHTS PUBLIC SCHOOLS
COLONIAL HEIGHTS, VIRGINIA
Parental Consent and Licensed Prescriber Authorization
For Administering Medicine
(Use a separate authorization form for each medicine)

PARENTAL CONSENT

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

Grade: _____ Team_____ Date of Birth: ____/____/_____

Allergies: _____

I am the parent or guardian of _____. I give permission for him/her to take the following prescribed medication while in _____ School. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medications. I hereby release _____ School and its employees from any claims or liability connected with such reliance. I authorize a representative of the school to share information regarding his/her medication with the licensed prescriber (listed below).

_____ _____ _____
Parent/Guardian Signature Daytime Telephone 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 prescribed medication is not given or is not given as prescribed: ____ Yes ____ No
   If yes, describe: _____
B. Serious reactions/adverse side effects from this medication can occur: ____ Yes ____ No
   If yes, describe: _____
   If yes, action/treatment for reactions: _____
   If yes, Report to you: ____ Yes ____ No (Drug information sheet may be attached)

Special Handling Instructions: ____ Refrigerate ____ Keep out of sunlight ____ Other
If other, please describe: _____

Asthmatic/Diabetic ONLY:
The student is capable and responsible for self-administering the medication: ____ Yes-Supervised ____ Yes-Unsupervised ____ No
The student may carry this medication: ____ No ____ Yes

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