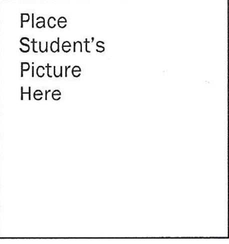
Loudoun County Public Schools
Authorization for Medication Administration



Student's Information

Last Name: ____________________ First Name: ________________ DOB: ______

Student ID #: ____________________ School: ________________ Grade: ______

Parent/Guardian: ________________ Cell: ________________ SY: ______

Has the student taken this medication before? ☐ Yes ☐ No If no, the first full dose should be given at home to decrease the risk of student having a negative reaction at school.

Prescription Medication: Healthcare Provider to Complete (one form for each medication)

Diagnosis/Condition for which medication is being administered: ____________________

Name of Medication: ____________________ Dosage: ____________________

Route: ________ Time of Administration: __________ Discontinue on Date: ________ or End of School Year: ☐

Special Considerations (open capsule, crush, mix, etc.): ____________________

List Possible Side Effects: ____________________

Healthcare Provider Signature: ____________________ Date: ____________

Healthcare Provider PRINTED Name/Stamp: ____________________

Healthcare Provider Phone: ____________________ NPI #: ____________

Healthcare Provider Address: ____________________

Over-The-Counter Medication: Parent/Guardian to Complete (one form for each medication)

Reason medication is to be given: ____________________

Name of Medication: ____________________

Dosage: ________________ Route: ____________ Time of Administration: ____________

Discontinue on Date: ________ or End of School Year: ☐

List Possible Side Effects: ____________________

Parent/Guardian Authorization

Parent/Guardian Name: ____________________ Phone: ____________

My signature gives permission for principal's designee to follow this plan, administer prescribed medication, and contact healthcare provider if necessary. I also agree to pick up any unused medication at the end of the school year. I understand that medication not picked up by a parent/guardian at the end of the school year will be discarded.

Parent/Guardian Signature: ____________________ Date: ____________

To Be Completed with Health Office Staff

Medication received: ____________________ Expiration Date: ____________

Medication received by: ____________________ / ____________________

Health Office Staff Signature/Date Parent Signature/Date