



MEDICATION AUTHORIZATION

Release and Indemnification Agreement



PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART I - PARENT OR GUARDIAN TO COMPLETE

I hereby request Fairfax County Public Schools (FCPS), Fairfax County Health Department (FCHD), and School Age Child Care (SACC) personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless FCPS, FCHD, SACC, and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for helping this student use medication, provided FCPS, FCHD, and SACC staff members comply with the physician, parent or guardian orders set forth in accordance with the provision of part II below. I have read the procedures outlined on the back of this form and assume responsibility as required.

Has the student taken this medication before? Yes No (If no, the first full dose must be given at home to ensure that the student does not have a negative reaction.)
First dose was given: Date _____ Time _____

Student Name (Last, First, Middle)

Date of Birth _____ School Name _____ School Year _____ Grade _____

No School Board employee, public health nurse, or school health aide shall administer medication or treatment, as an exception under School Board policy, unless the principal or his or her designee has personally reviewed all the required clearances.

Parent or Guardian Signature _____ Daytime Telephone _____ Date _____

PART II - PARENT OR GUARDIAN TO COMPLETE AND SIGN FOR OVER-THE-COUNTER MEDICATION FOR RELIEF OF SYMPTOMS FOR HEADACHE, MUSCLE ACHES, ORTHODONTIC PAIN, OR MENSTRUAL CRAMPS AND FOR ANTIBIOTIC AND ANTIVIRAL MEDICATION. PHYSICIAN MUST COMPLETE AND SIGN FOR ALL OTHER MEDICATIONS.

The Fairfax County Health Department and Fairfax County Public Schools discourage the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and overnight field trips and school crisis situations according to the procedures outlined on the back of the form. Information should be written in lay language with no abbreviations.

Diagnosis _____

I give permission for over-the-counter medications to be supplied to my child per the Supplemental Medication

Medications _____

Authorization Form.

If medication is given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time at which it may be given again.

Dosage to be given at school or SACC, (e.g. mg, ml, or cc) _____ Per label _____ Time(s) or interval between times to be given per label _____

Effective date

Current School Year From _____ To _____

If the student is taking more than one medication at school, list sequence in which medications are to be taken

Physician Name (Print or Type) _____ Physician Signature _____ Telephone or Fax _____ Date _____

Parent or Guardian Name (Print or Type) _____ Parent or Guardian Signature _____ Telephone _____ Date _____
(Not required if physician signs)

PART III - PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE

Check as appropriate

Parts I and II above are complete including signatures. (It is acceptable if all items in part II are written on the physician's stationery or a prescription pad.)

Medication is appropriately labeled. _____ Date by which any unused medication is to be collected by the parent. (Within one week after expiration of the physician order or on the last day of school.)

Principal or Designee Signature _____ Date _____

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent, guardian, or eligible student.

*** For use with Supp Med Form ***

Complete

Complete