Attachment I
Section A
Regulation 757-4

OVER-THE-COUNTER OR PRESCRIBED MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PHYSICIAN - *ONE FORM PER MEDICATION

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 be administered by school personnel.

Student: ___________________ **DOB:** _________ **SCHOOL:**______________

Reason for medication: ____

Name of medication: ____

Dosage and time: ____

Symptoms for repeating medication: ____________________________________

Duration: ____

Date of prescription: ____

Date: _____________________ **Name of physician:** _________________________
(Print)

Signature of physician: _______________________

Note: Please return this form with medication, or have your physician mail or fax it back to your child's school, Attention: School Nurse.

Attachment I
Section B

OVER-THE-COUNTER OR PRESCRIPTION MEDICATION REQUEST BY PARENT/GUARDIAN

Student: __________________ **DOB:** _________ **School:**_______________

Reason(s) medication is to be given: ________________________________

Name of Medication: ____

Dosage and time to be given: ____

Duration: ____

I/We agree to furnish the medication in the **ORIGINAL** sealed container with the label intact. **A physician must authorize in writing any nonprescription medication that is to be given for more than the recommended duration as written on the label or manufacturer's recommendation.** I/We authorize the school nurse to communicate with the physician as allowed by HIPAA. I/We are aware that non-medical personnel may be administering medication to my child. **I/We hereby release the Prince William County School District and all of its employees of and from any and all liability in law for damages either we or our child may incur as a result of this request.**

Date: ________________________ ____________________________________
Signature of Parent/Legal Custodian

Attachment VI
Regulation 757-4

Medication Permission Form
For Extended Day/Overnight Field Trips
(One form for each medication)

Any medication that must be administered during an overnight field trip, either over the counter or prescribed requires a physician's written order and a parent/guardian authorization. A signed permission form is necessary for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc. Only FDA approved medicines will be accepted. The required medications shall come in the original container with proper labeling. This permission form is valid for the current field trip only. Medications may only be given by Prince William County Public School employees unless an accompanying parent administers it to their own child.

I hereby certify that it is necessary for ______________________________ DOB:________
(Students Full Name)

Teacher/Homeroom: ______________________ Grade: _____ School:________________
to be administered the medication listed below when she/he is away from school property on an approved school field trip.

Name of Medication:____

Reason for Medication (Diagnosis):_____________________________________

Dosage to be given:______________________Route (mouth, injection, etc.)____________

Time(s) of administration: ________________Allergies: _______________________

Beginning Date: _______ Ending Date:_______ Amount of Liquid or Count of Pills: _______

Physicians Signature: ___________________________________ Date: _______________

Emergency Telephone Numbers:

Parent/Guardian: ____________________H:__________W:__________C:____________

Parent/Guardian: ____________________H:__________W ___________C:___________

Doctor's Name: ____Phone:________________

Parents are requested to pick up any leftover medication at the end of the field trip. Medications that are left after this time will be discarded.

(continued on back)

I hereby consent to protected health information being used and disclosed to carry out treatment or health care of my child. I understand that Prince William County Public School (PWCS) District may need to give and receive protected health information pertaining to the management of my child's medical condition with the health care provider listed above, and I hereby authorize the exchange of this information as needed to carry out the treatment or health care of my child. I also give permission for the information on this form to be reviewed and utilized by staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby authorize PWCS employees to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his or her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration specific to this field trip, may assist my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on this record.

I/We hereby release the PWCS District and all of its employees of and from any and all liability in law for damages either we or our child may incur as a result of this request.

Signature of Parent/Legal Guardian______________________________ Date:________