

**RADFORD CITY SCHOOLS**  
**School Medication Authorization Form**

We encourage parents to have a child's medication administered at home and not at school, if at all possible. However, if your physician decides it is necessary for your child to receive a medication during the school day, approval and specific directions must be provided to the school. It is recommended that the first doses of medication be administered at home.

Send the medication to the school in the original or duplicate bottle or box with the current prescription label on the container. Upon request, pharmacists will label empty containers to be used.

**Please take this form to the physician** to record instructions regarding the administration of your child's medication.

Student's name:	Birth date:
Address:	
Home phone:	Emergency phone:
School:	Grade: Teacher:

***To be completed by the student's physician:***

Name of medication:		
Dosage:	Frequency:	Time to be given in school:
Date of prescription:	Date of order:	Discontinuation date:
Diagnosis requiring medication:		
Intended effect of this medication:		
Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition?		
Expected/possible side effects, if any:		
Time interval for re-evaluation:		
Other medications student is receiving:		
<b><i>Physician's signature:</i></b>		<b><i>Date:</i></b>
<b><i>Physician's name (please print):</i></b>		
<i>Physician's Office Address:</i>		
<i>Physician's Office phone:</i>		<i>Emergency phone:</i>

I confirm that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the Radford City School Division and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the school division), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and I specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school division, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the school division, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent(s)/Guardian(s) signature:	Date:
Parent(s)/Guardian(s) name (please print):	