STUDENT MEDICATION ADMINISTRATION FORM

School Year: _____ School: _____ Grade: _____

Child's Name: _____ Date of Birth: _____

Medications are administered at school according to the medication policy for Goochland County Public Schools.
All prescription medication must have a physician's signature on this form.

Medication: _____

Dosage: _____

Time to Administer: _____

Route: _____

Reason Taken: _____

_____ _____

Physician's Name (please print) Physician's Signature

Physician's Phone Number: _____ Physician's Fax Number: _____

I request the above student to be given this medication at school by staff designated to administer medications. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medications where the person administering the medication acts as an ordinary reasonably prudent person would under the same or similar circumstances. **I agree for an adult to deliver medication to and from school and to pick up remaining medication at the end of the school year or it will be properly destroyed within 30 days.**

AUTHORIZATION SIGNATURE:

I, _____, (☐ do) (☐ do not) authorize my child's health care provider and the school setting health care provider to exchange information pertaining to this form.

_____ _____

Parent/Guardian Authorization Signature Date

Address: _____

Email Address: _____

Home Phone/ Cell Phone/ Work Phone: _____

School Nurse Contact Information:
Randolph Elementary: 804.556.5385 (phone); 804.784.2674 (fax)
Goochland Elementary: 804.556.5321 (phone); 804.556.6054 (fax)
Byrd Elementary: 804.556.5380 (phone); 804.457.9303 (fax)
Goochland Middle: 804.556.5320 (phone); 804.556.6223 (fax)
Goochland High: 804.556.5322 (phone); 804.556.6485 (fax)