

Appomattox County Public Schools

Physician's Order and Parent/Guardian Permission for Medication Administration

Student Information:

Student Name: _____

Date of Birth: _____

Physician's Order: (To be completed by Physician)

Medication: _____

Dosage: _____

Route (oral, inhaled, topical, etc.): _____

Time(s) to be given: _____

Duration of Order: _____

Diagnosis/Reason for Medication: _____

Physician Signature: _____ Date: _____

Parent/Guardian Permission

I, the parent/guardian of the above student, give permission for the school nurse or designated staff member to administer the above medication to my child during school hours. I understand that Appomattox County Public Schools and its employees are not responsible for any side effects the medication may cause.

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____

Date: _____

School Nurse Use Only:**Chain of Custody**

Date medication received in clinic: _____

Amount of Medication Received: _____

Nurse Signature: _____

Parent/Guardian Signature: _____

Additional Inventory Received:

Date medication received in clinic: _____

Amount of Medication Received: _____

Nurse Signature: _____

Parent/Guardian Signature: _____

Date medication received in clinic: _____

Amount of Medication Received: _____

Nurse Signature: _____

Parent/Guardian Signature: _____

Date medication received in clinic: _____

Amount of Medication Received: _____

Nurse Signature: _____

Parent/Guardian Signature: _____

Date medication received in clinic: _____

Amount of Medication Received: _____

Nurse Signature: _____

Parent/Guardian Signature: _____

Date medication Ended: _____ Amount of Medication Left: _____

Reason for Ending: _____

Picked up or Wasted

Nurse Signature: _____

Parent/Guardian Signature: _____

Witness Signature if Wasted: _____