FAUQUIER COUNTY PUBLIC SCHOOLS

AUTHORIZATION FOR MEDICATION ADMINISTRATION **BUS #_____**

PARENT/GUARDIAN SECTION

Student_____DOB_____Age_____Grade_____
School_____Homeroom Teacher_____
Parent/Guardian Signature_____Date_____
Parent/Guardian Printed Name_____
Signature gives permission for principal's designee to administer prescribed medicine and gives principal's designee permission to contact physician/dentist if necessary. For Over-the-Counter medicine, parent's signature gives principal's designee permission to administer medicine.

PHYSICIAN/DENTIST SECTION
(Must be completed by Physician/Dentist)

PRESCRIPTION MEDICATIONS:
Name of Medication:_____

Reason medication is needed, unless confidential:_____

Dosage:_____Length of Time:_____

Time to be given:_____
If potentially serious side effects exist, please outline any necessary emergency response on a separate sheet.

Physician/Dentist Signature_____Date_____

Physician/Dentist PRINTED Name_____

Physician/Dentist Phone_____Fax_____

Physician/Dentist Address_____

OVER-THE-COUNTER MEDICATIONS:

Name of Medication:_____

Dosage/Length of Time:_____

Time of Day to be given:_____

Side effects:_____

Received by_____**Date**_____