

**MEDICATION PERMISSION FORM**

| Date<br>Received | Medication<br>Name | Quantity<br>Received | Received<br>from | Exp.<br>Date | Nurse<br>initials |
|------------------|--------------------|----------------------|------------------|--------------|-------------------|
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**Initial:** entered in Welligent \_\_\_\_\_ **Scanned into Welligent** \_\_\_\_\_  
**Nurse signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Notes:**

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**Medication count- Dates:**

Aug. \_\_\_\_\_ Sept. \_\_\_\_\_ Oct. \_\_\_\_\_ Nov. \_\_\_\_\_ Dec. \_\_\_\_\_  
Jan. \_\_\_\_\_ Feb. \_\_\_\_\_ March \_\_\_\_\_ April \_\_\_\_\_ May \_\_\_\_\_  
June \_\_\_\_\_ July \_\_\_\_\_

**\*\* Must Document in Welligent**

**TO BE COMPLETED BY PHYSICIAN**

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 may be administered by school personnel.

**Prescription:**

Medication \_\_\_\_\_

Dosage & Time \_\_\_\_\_

Duration \_\_\_\_\_

Date of Prescription \_\_\_\_\_

Diagnosis requiring medication \_\_\_\_\_

Date \_\_\_\_\_

Signature of Physician

Phone# \_\_\_\_\_

Printed Physician signature

**TO BE COMPLETED BY PARENT/LEGAL CUSTODIAN**

I, \_\_\_\_\_, the parent or legal custodian of \_\_\_\_\_ request that the clinic attendant, school nurse or principal's designees administer the above medication to the above named student during the school hours and at the times indicated. I agree to furnish said medication in the **ORIGINAL** container supplied by the pharmacy with the label intact. I understand and accept that the Henrico County School Board, its employees, agents or designees are not responsible for any effects of the medication administered.

Date \_\_\_\_\_

Signature of Parent/Legal Custodian

Home Tel. No. \_\_\_\_\_

Work Tel. No. \_\_\_\_\_

**NOTE: PLEASE RETURN THIS FORM WITH MEDICATION OR HAVE YOUR PHYSICIAN MAIL OR FAX IT BACK TO YOUR CHILD'S SCHOOL, ATTN: SCHOOL NURSE**