

AUTHORIZATION FOR ADMINISTERING PRESCRIPTION MEDICATION

**\*USE A SEPERATE AUTHORIZATION FORM FOR EACH MEDICATION\***

Student's Name \_\_\_\_\_

PARENTAL CONSENT

I am the parent or legal guardian of \_\_\_\_\_ . I give my permission for him/her to take the following prescribed medication while attending the Virginia Governor's School for Agriculture. I hereby release the Virginia Governor's School for Agriculture and its agents and employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless of any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the licensed prescriber.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Daytime Phone

\_\_\_\_\_  
Date

\*\*\*\*\*  
**MEDICATION AUTHORIZATION**  
\*\*\*\*\*

(This section to be completed by **Licensed Prescriber** only! Please print or type.)

Relevant Diagnosis (please describe any problems associated

Medication: \_\_\_\_\_

Dates medication must be administered at school:  Short Term \_\_\_\_\_ - \_\_\_\_\_  
 Every Day  
 Episodic/Emergency Events ONLY

Dosage (Amount): \_\_\_\_\_ Route: \_\_\_\_\_ Form: \_\_\_\_\_ Time(s) of day: \_\_\_\_\_

A. Can serious reactions occur if the medication is not given at the time prescribed, or if a dose or dosages are missed?  
If YES, please describe: \_\_\_\_\_

B. Do serious reactions/adverse side effects from this medication occur? If YES, please describe:

C. Action treatment for reactions: \_\_\_\_\_  
(Drug information sheet may be attached)

Special handling instruction:  Refrigeration  Keep out of sunlight  Other: \_\_\_\_\_

This student is both capable and responsible for self-administering this medication:  
 No  Yes-supervised  Yes-unsupervised

**The Governor's School assumes students are medically stable and able to self-administer all prescribed medications. If there are any contradictions or disabilities that would preclude this student from self-administration of medication, please explain on the reverse of this form.**

\_\_\_\_\_  
Licensed prescriber's name: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Emergency number: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_