

The Congressional Schools and Camp of Virginia

AUTHORIZATION TO GIVE MEDICATION

The Commonwealth of Virginia requires Licensed Day Care Centers, Accredited Schools and Camps to maintain control over all medications entering the campus. Regulations concerning the administration of medication to children are specific.

- All persons under the age of 18 are regarded as minors and require parent/guardian permission to receive or carry medication.
- This form must accompany the medication to be given.
- Parent/Guardian must provide all over the counter medications as well as prescription medications to be given at school, camp, or day care.
- Minors are not permitted to self medicate. (Some exceptions may be made with the mutual, written understanding of the Parent, Child, Physician, and Nurse.)
- All medication should be surrendered to the clinic. Failure to do so could result in disciplinary action.

NON-PRESCRIPTION MEDICATIONS:

(Includes all "Over The Counter" type of medication)

1. Must be in an original pharmacy container.
2. Must be labeled with the child's name.
3. May be administered by authorized personnel ONLY with the written consent of the Parent/Guardian.
4. Are permitted for a period of three days. (Weekends or holidays terminate the permission period.)

PRESCRIPTION CONTROLLED MEDICATIONS:

1. Must have an authentic pharmacy label correctly listing the child's name, medication, valid date, and instruction for administration.
2. May be administered ONLY with the written consent of the Parent/Guardian.
3. Standing Orders are terminated at the completion of the school year, end of camp session (s) attended, or at the request of parent or physician. **A physician's written instruction is required to keep medication on campus for occasional or emergency use.**

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Child's Name: _____ **Teacher/Counselor:** _____

The School/Camp Nurse or other authorized personnel has my permission to administer the following medication to the above named child.

Drug Name/Prescription Number: _____

Reason for taking medication: _____

Dosage to be given: _____ **Time to be Given:** _____

Allergies or special instruction (e.g. give with food): _____

Term of therapy: _____

The School Nurse may contact my child's physician for clarification, if necessary.

Physician's Name: _____ **Office Phone:** _____

This confidential information may be shared with professional staff of The Congressional Schools and Camp or emergency personnel if necessary.

Signature of Parent/Guardian: _____ **Date:** _____

**PLEASE LEAVE THIS FORM AND THE MEDICATION WITH THE NURSE
or Other Adult in the Schools, Camp, or Early Childhood Programs.**

