

MEDICATION AUTHORIZATION

Release and Indemnification Agreement



PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

PART I PARENT OR GUARDIAN TO COMPLETE			
I hereby authorize Fairfax County Public Schools (FCPS), Fairfax County Health Department (FCHD), and School Age Child Care (SACC) personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless FCPS, FCHD, SACC, and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for helping this student use medication, provided FCPS, FCHD, and SACC staff members comply with the licensed prescriber, parent or guardian orders set forth in accordance with the provision of Part II below. I have read the procedures outlined on the back of this form and assume responsibility as required.			
Has the student taken this medication before? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If no, the first full dose must be given at home to ensure that the student does not have a negative reaction.) First dose was given: Date _____ Time _____			
Student Name: Last _____		First _____	Middle _____
Date of Birth _____	School Name West Springfield High School		School Year 25-26
Grade _____			
No School Board employee, public health nurse (PHN), licensed practical nurse (LPN), or school health aide shall administer medication or treatment, as an exception under School Board policy, unless the principal or his or her designee has personally reviewed all the required clearances. I give permission for the Public Health Nurse (PHN) to contact the below named licensed prescriber to clarify information provided on the order should the need arise.			
Parent or Guardian Signature _____	Daytime Telephone _____		Date _____
PART II PARENT OR GUARDIAN TO COMPLETE AND SIGN FOR OVER-THE-COUNTER MEDICATION PER MANUFACTURER'S RECOMMENDATION FOR RELIEF OF SYMPTOMS FOR HEADACHE, MUSCLE ACHE, ORTHODONTIC PAIN, OR MENSTRUAL CRAMPS FOR THE ENTIRE SCHOOL YEAR. OVER-THE-COUNTER MEDICATIONS FOR SYMPTOMS OTHER THAN HEADACHE, MUSCLE ACHES, MENSTRUAL CRAMPS, ORTHODONIC PAIN, INCLUDING ANTIBIOTICS, AND ANTIVIRAL MEDICATIONS MAY BE GIVEN FOR TEN CONSECUTIVE SCHOOLDAYS WITH ONLY THE PARENT OR GUARDIAN'S SIGNATURE. LICENSED PRESCRIBER MUST COMPLETE AND SIGN FOR ALL OTHER MEDICATIONS.			
The Fairfax County Health Department and Fairfax County Public Schools discourage the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and overnight field trips and school crisis situations according to the procedures outlined on the back of the form. Information should be written in lay language with no abbreviations.			
Diagnosis Sunburn, Itching, Headache, Stomach Pain, Cramps, Muscle Pain			
Medication See Attached OTC Medications		Route (Oral, Injection, Inhalation, Topical, Buccal, Rectal, etc.) Oral or Topical	
If medication is given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time between doses. Upon occurrence of diagnosis			
Dosage to be given at school or SACC, (e.g. mg, ml) As directed on package		Time(s) or interval between doses As directed on package	
Effective Date: _____ <input type="checkbox"/> Current School Year OR <input checked="" type="checkbox"/> From 5/14/2026 To 5/26/2026		If the student is taking more than one medication for the same symptom(s), list sequence in which medications are to be taken:	
N/A	_____	_____	_____
Licensed Prescriber Name (Print or Type)	Licensed Prescriber Signature	Telephone or Fax	Date
Parent or Guardian Name (Print or Type) (Not required if licensed prescriber signs)	Parent or Guardian Signature	Telephone	Date
PART III PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE			
Check <input checked="" type="checkbox"/> as appropriate: <input type="checkbox"/> Parts I & II above are complete including signatures. (It is acceptable if all items in Part II are written on the licensed prescriber's stationery or a prescription pad.) <input type="checkbox"/> Medication is appropriately labeled. _____ Date by which any unused medication is to be PICKED UP by the parent or guardian. (Within one week after expiration of this authorization or on the last day of school.)			
Principal or Principal Designee Signature _____	Date _____	Student ID _____	

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent, guardian, or eligible student.

West Springfield High School Crew
Supplemental Medication Authorization Form



This form will only be used in conjunction with a completed and signed FCPS Medication Authorization form. If a signed FCPS form is not on file, we cannot administer any medication to the student. To provide any over-the-counter medication to a student, **BOTH the FCPS Medication Authorization form and this Supplemental Medication Authorization form must be signed.**

I, _____, authorize previously designated members of the WSHS Spartan Crew and/or FCPS employees to administer the following over-the-counter medication as per package instructions for my child, _____ for ailments for which the medication is designed, for the duration of the Stotesbury Regatta Field Trip & SRAA Nationals Field Trip.

None of the medications will be given in a dosage that exceeds the recommended amount on the package.

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Advil | <input type="checkbox"/> Pepto Bismol |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Tums |
| <input type="checkbox"/> Midol | <input type="checkbox"/> Neosporin |
| <input type="checkbox"/> Dramamine | <input type="checkbox"/> Visine |
| <input type="checkbox"/> Benadryl | <input type="checkbox"/> Saline (Contact Lenses) |

I also consent to the following prescription medications and/or emergency treatment as per my written instructions provided on a separate Medication Authorization Form provided to WSHS Spartan Crew Team:

Parent/Guardian Signature:
