Student Health Services

AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

PARENT MUST SUPPLY MEDICATION TO BE STORED AT SCHOOL

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, on a field trip or during a school chaperoned "before" or "after" school activity, this form must be completed.

STUDENT'S NAME: ____

HOMEROOM TEACHER: ______________________________ GRADE: ____________

KNOWN ALLERGIES: ____

I hereby request that the Fulton County School System, through the principal or designee, supervise/assist in the administering of medication to my child, according to the instructions contained in the statement below.
I understand that:

- Medications (both prescription and non-prescription) **must** be in the original labeled container (no baggies, foil, etc).
- Parent/guardian must give the school clinic specific instructions regarding medication usage, as well as the medication and related equipment.
- It will be the responsibility of the parent/guardian to inform the school of any changes with the medication - new medication or new doses **will not** be given unless a new form is completed.
- All medication should be taken directly to the office/clinic by the parent and/or student.
- Unused medication will be disposed unless picked up within one week after medication is discontinued.
- School employees will not assume any liability for supervising or assisting in the administration of medication.
- Completion of this form for Prescription Medication authorizes Student Health Services to discuss the medication order/request with the prescribing health care provider if indicated and/or needed.

✓Check the Appropriate Box: ➔ ☐Prescription Medication ☐Non-Prescription Medication

NAME OF MEDICATION AND REASON FOR TAKING: ______________________________

DOSAGE AND TIME OF ADMINISTRATION: ______________________________

STOP MEDICATION: ______________________________

I release the school board, the school, and any school employee from any liability for administering this medication.

______________________________ ______________________________

PARENT/LEGAL GUARDIAN SIGNATURE DATE

Home Phone: ____________ **Work Phone:** ____________ **Cell Phone:** ____________

THIS SECTION TO BE COMPLETED BY PHYSICIAN FOR ALL PRESCRIPTION MEDICATIONS

(If the prescription medication box above is checked, the physician must thoroughly complete and sign this section)

CONDITION/ILLNESS REQUIRING MEDICATION: ______________________________

POSSIBLE SIDE EFFECTS: ______________________________

PHYSICIAN'S SIGNATURE: ______________________________

PHYSICIAN'S NAME & CONTACT NUMBER (*print legibly*) ______________________________

This Section to be completed by Clinic Assistant/Cluster Nurse/Special Needs Nurse ONLY

Received Date: __________ Medication: ____________ # of doses: _____ Expiration date: __________

Returned Date: __________

Revised 06/08