Authorization to Give Medication at School

Student Name: _____ **DOB** _____/_____/_____ **Grade:** _____

Teacher/Homeroom: _____ **Parent/Guardian:** _____

- I understand that the school nurse will administer, or supervise/assist in the administration of medication to my child according to the instructions listed below.
- I understand that medications must be in the original labeled container (no baggies, foil, etc.) Note: Pharmacist can provide duplicate labeled container with only the school dosage.
- I understand that a parent/guardian must provide specific instructions as well as the medication and related equipment to the principal or clinic personnel.
- I understand that it is the responsibility of the parent/guardian to inform the school of any changes in medication, doses, time of administration, etc. New medication or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- All medication will be taken directly to the Clinic/Office by the parent/guardian.
- Unused medication will be disposed of unless picked up by the parent/guardian within one (1) week after medication is discontinued.

Name of Medication: _____

Dose(s): _____ **Route (by mouth, topical, etc.):** _____

Time(s) medication is given: _____ **Terminate medication on:** _____

Diagnosis or condition requiring medication/treatment: _____

Reason and/or goal of the medication: _____

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

I hereby authorize the school nurse, and other personnel as authorized, to assist my child in taking prescribed medication according to Board Policy JGCD and JGCD-R. I hereby release, and covenant not to sue, the Walton County School District, and its employees, from liability in connection with any claims arising out of the administration of medication. Completion of this form for prescription medication authorizes the school system to discuss the medication order with the prescribing Physician if indicated or needed.

Parent/Legal Guardian Signature: _____ **Phone:** _____

Physician Authorization

TO BE COMPLETED BY HEALTHCARE PROVIDER FOR ANY PRESCRIPTION GIVEN FOR MORE THAN TWO WEEKS

Medication: _____ **Prescribed Medication Date:** _____

Diagnosis or condition requiring medication/treatment: _____

Possible Side Effects (if any): _____

Rehabilitation Potential (if any): _____

Signature of Healthcare Provider: _____ **Date:** _____

******TO BE COMPLETED BY SCHOOL HEALTH CLINIC PERSONNEL ONLY******

Date Received: _____ **Name of Medication:** _____ **Dose(s):** _____

Expiration Date: _____ **Completed by:** _____ **Date returned to legal guardian:** _____

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