Student Health Services

AUTHORIZATION TO GIVE MEDICATION AT SCHOOL
PARENT MUST SUPPLY MEDICATION TO BE STORED AT SCHOOL

This form must be completed if medication has to be administered during school hours, field trips or during a school chaperoned "before" or "after" school activity. Please give all medications at home before or after school hours when possible.

STUDENT NAME: _____ **DOB:** _____ **SCHOOL YEAR:** _____

HOMEROOM TEACHER: _____ **GRADE:** _____ **KNOWN ALLERGIES:** _____

I hereby request Fulton County Schools System, through the principal or designee, to supervise/assist with administering this 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/Legal Guardian is responsible for assuring the School receives specific instructions regarding medication usage, including the medication and related equipment;
- The Parent/Legal Guardian is responsible for informing the school of any changes with the medication - new medications or new doses **WILL NOT** be given until a new form is completed;
- All medication should be taken directly to the School Office/Clinic by the Parent and/or Student;
- All unused medication will be properly disposed at the end of this school year if it is not 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 healthcare provider if indicated and/or needed.**

NON-PRESCRIPTION MEDICATION (TO BE COMPLETED BY PARENT/LEGAL GUARDIAN)

MEDICATION NAME:		CONDITION/ILLNESS REQUIRING MEDICATION:
START DATE:	STOP DATE:	DOSAGE AND TIME(S) OF ADMINISTRATION:

I release Fulton County Schools System and any Fulton County Schools System employee from any liability associated with administering this medication. **Parent/Legal Guardian authorization signature is needed for both prescription and non-prescription medications.**

_____ _____ _____
PARENT/LEGAL GUARDIAN SIGNATURE | PRINT NAME LEGIBLY | DATE

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PRESCRIPTION MEDICATION (TO BE COMPLETED BY PHYSICIAN/HEALTHCARE PROVIDER)

MEDICATION NAME:	PRESCRIBED DOSAGE:
POSSIBLE SIDE EFFECTS:	ADMINISTRATION AND OTHER SPECIAL INSTRUCTIONS:
CONDITION/ILLNESS REQUIRING MEDICATION:	

_____ _____ _____
PHYSICIAN'S SIGNATURE | PRINT PHYSICIAN NAME LEGIBLY | DATE

Office/Contact Number: _____ Fax: _____

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

DATE RECEIVED:	MEDICATION NAME:	# OF DOSES:
EXPIRATION DATE:	DATE RETURNED TO LEGAL GUARDIAN:	COMPLETED BY: