

COLUMBIA COUNTY SCHOOL SYSTEM
AUTHORIZATION TO GIVE MEDICATION 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, this form must be completed.

STUDENT'S NAME: _____

TEACHER/GRADE: _____

I hereby request and authorized the Columbia County School System, through the principal or designee, to supervise/assist in the administering of medication to my child, _____, according to the instructions contained on the statement below.

I understand that:

Medications must be in the original labeled container (no baggies, envelopes, foil, etc.).

Parent/guardian must provide specific instructions, as well as the medication and related equipment to the principal or clinic personnel.

It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed.

The student will take all medication directly to the office/clinic upon immediate arrival if he/she is transporting medication.

Unused medication will be disposed of unless picked up within one week after medication is discontinued.

If this is an "as needed" medication, it will not be administered until parent/guardian can be reached by phone each time my child is requesting this medication. Please understand that this is for the child's safety to prevent accidental overdose either at home or at school.

The sharing of medical information with other health-related agencies may be necessary.

NAME OF MEDICATION: _____

DOSAGE/TIME OF ADMINISTRATION: _____

START: Date form received or Date: _____

STOP: End of school year or Date: _____

For emergency use only As needed

START/STOP MEDICATION ON: _____

I forever release and hold harmless the school board, the school, and any school employee from any liability which may result from administering this medication.

PARENT/LEGAL GUARDIAN SIGNATURE

DATE

Home Phone: _____ Work Phone: _____ Pager/Cell Phone: _____

PHYSICIAN'S NAME: _____ **PHONE:** _____

In order for school officials to administer any herbal/alternative medication or dietary supplement, or a prescribed medication for a period greater than ten days, the following information must be provided by a State of Georgia licensed physician:

CONDITION/ILLNESS REQUIRING MEDICATION: _____

POSSIBLE SIDE EFFECTS, IF ANY: _____

SIGNATURE OF PHYSICIAN: _____ DATE: _____