

Fulton County Schools
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 provide specific instructions, as well as the medication and related equipment to the school clinic.
- 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 of 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.

Circle one: Prescription or Non-prescription

NAME OF MEDICATION AND REASON FOR TAKING: _____

DOSAGE AND TIME OF ADMINISTRATION: _____

STOP MEDICATION ON: _____

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: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER FOR PRESCRIPTION MEDICATIONS

(If prescription medication, have physician/health care provider complete and sign the following portion)

CONDITION/ILLNESS REQUIRING MEDICATION: _____

POSSIBLE SIDE EFFECTS, IF ANY: _____

SIGNATURE OF HEALTH CARE PROVIDER: _____

PHYSICIAN NAME AND NUMBER (Print) _____

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To be completed by Clinic Assistant/Cluster Nurse/Special Needs Nurse only:

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

Revised 05/07