

**City Schools of Decatur
School Health Program**

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 request that the _____, through the principal or designee, supervise/assist in the administering of medication to my child, according to instructions the statements below. I understand that:

- Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacists can provide a duplicate labeled container with only the school doses.
- 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 and a newly labeled container is provided.
- All medication will be taken directly to the office/clinic by the parent.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

Name of Medication: _____

Dose _____ **Route (by mouth, topical, etc)** _____

Time(s) to be given _____ **Stop Medication On** _____

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any: _____

Healthcare Provider's Name: _____ **Phone:** _____

I hereby authorize the personnel, employees and officials of the City Schools of Decatur to assist my child in taking prescribed medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

Parent/ Legal Guardian signature

Date

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