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.
- Completion of this form for PRESCRIPTION MEDICATION authorizes School Health staff to discuss the medication order/request with the prescribing healthcare provider as needed.

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 according to district policy and I release them from any liability for administering this 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:** _____

Medication pick up: Parent/Legal guardian signature: _____ Date:_____

Revised 5/2016