CHEATHAM COUNTY SCHOOL DISTRICT

School Health Services

AUTHORIZATION FOR MEDICATION ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION* MEDICATION

**NOTE: Non-prescription medication can only be given for 3 consecutive days without written authorization from a physician. If there is a need for a non-prescription medication to be taken for more than 3 consecutive days, this will require written authorization from a physician.*

Many children and adolescents require medication to maintain an optimal level of functioning at school. It is encouraged that medication be given at home. However, it is noted that in some situations medication must be given at school. Medications must be brought to school by the parent/guardian with the signed permission form on file at the school. Non-prescription medication (such as Tylenol, antacids, cough medications, etc.) must be provided by the parent in an unopened container with the child's name on the container and must be accompanied by this authorization form. It is the responsibility of the parent to remove any unused medication from the school within 7 days of the last day of scheduled administration or the medication will be discarded by the school nurse. **NO MEDICATION SHALL BE TRANSPORTED BY STUDENTS.**

To be completed by physician, or parent/guardian if non-prescription for less than 3 consecutive days.

Student's Name_____ School Year _____

School _____ Grade _____ DOB _____ Physician's Name _____

Physician's Address _____

Physician's Phone _____ Physician's Fax _____

Name of Medication:_____ Dosage: _____

Time(s) Medication is to be taken: _____

How soon can medication be repeated? _____

Route of administration (by mouth, topical, inhalation, etc.) _____

Date started _____ Date to be discontinued _____

Purpose of medication _____

Possible side effects _____

If inhaler/epi-pen, is student allowed to carry it? Yes No

_____ _____

Physician's Signature *Date*

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent/guardian. In consideration of the acceptance of the request to perform this service by any person employed by the Cheatham County School District, the undersigned parent/guardian hereby agrees to release Cheatham County School District and its personnel from any legal claim which they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student. I will assume full responsibility for any side effects and complications that my child may have as a result of taking this medication. I hereby give my permission for _____ to take the above medication as ordered. My child is competent to self-administer this medication with assistance. I understand that it is my responsibility to furnish, to deliver, and to pick-up this medication when completed. I understand that my child will be self-administering this medication with the assistance of appropriate school personnel. I agree to allow my child's healthcare provider and school nurses to communicate as needed regarding the information on this form.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Name Printed: _____

Contact Information: Phone _____ **Work** _____ **Cell** _____

Emergency Contact: _____ **Phone** _____

Revised 07/2018