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 that the Burke County School System, through the principal or designee, 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, 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 and a newly labeled bottle is provided.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

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Name of Medication: _____

Time(s) to be given: _____ **Dose:** _____ **Route:** _____

Stop Medication On: _____

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

I release the school board, the school, and any school employee from any liability for administering this medication. I further authorize the health care provider, named above, to discuss information regarding findings, treatment, and opinions relating to the medical condition of the student named above.

_____ _____

Parent/Legal Guardian Signature **Date**

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

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To be completed by healthcare provider for all medications required for two weeks or more.

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any: _____

_____ _____

Signature of Healthcare Provider **Date**

Date received: _____ **Name of Medication:** _____ **#Doses:** _____

REV. 8/03