PERMISSION FOR MEDICATION
ATHENS CITY SCHOOLS

NOTE: If possible, parents are advised to give medication at home and on a schedule other than during school hours. If it is necessary for a medication to be given during school hours, the following regulations must be followed:

1. Present this "Permission for Medication" form signed by the parent or legal guardian.
2. Bring the medication IN THE ORIGINAL PRESCRIPTION BOTTLE, properly labeled by a registered pharmacist as prescribed by law, or in an ORIGINAL NON-PRESCRIPTION BOTTLE. IF MEDICATION IS NOT PROPERLY LABELED, IT WILL NOT BE GIVEN.

I give my permission to (circle one) ACMS CP IS NC WS School to administer to

Student ______________________________

the following Medication ____________________ **Dosage** __________

Time of day medication to be given __________ **a.m.** __________ **p.m.**

Recommended by Dr. ______________________________

Condition necessitating use of this medication ____________________

Possible side effects ______________________________

Anticipated number of days medication needs to be given at school:

Starting date __________ **Ending date** __________

It is understood that this medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by any person employed by the Athens City Schools, the undersigned parent or guardian hereby agrees to release the Athens City School System 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 hereby give my permission for the school to assist my child in taking the above prescription as ordered. I understand that it is my responsibility to provide this medication in the original prescription container.

____________________ ____________________

Date **Signature of Parent or Guardian**

Teacher __________

____

Phone Number(s) in case of emergency

Grade _______

Theda Plemons, RN
Amanda Curtis, RN

School Nurses

May 2018

RECORD OF MEDICATION ADMINISTRATION
ATHENS CITY SCHOOLS

STUDENT'S NAME____ Teacher____________________ Grade_____

MEDICATION_______________________________________ TIMES TO BE GIVEN ________ a.m. ________p.m.

DOSAGE_______________ or every ____________ hours as needed

Day	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug.																															
Sept																															
Oct.																															
Nov.																															
Dec.																															
Jan.																															
Feb.																															
Mar.																															
Apr.																															
May																															

Teacher	Initials

Please put your initials in the correct box when medication is given (add the time given for prn meds), and have the student sign their initials when age appropriate. All information concerning medication (side effects, duration, etc.) can be found on the Permission for Medication Form on the reverse side of this paper.