Newton County School District
Medication Authorization

Elementary School Nurse: Patty Gibson, RN
Phone: 601-635-2325 or 601-635-2956
Fax: 601-635-4074

Middle/High School Nurse: Rae Hollingsworth, RN
Phone: 601-635-2718 or 601-635-3347
Fax: 601-635-4045

All students who need medication during school hours must do the following:

- Students are not allowed to transport any medications to or from school, nor are they to have any medications in their possession on school campus. The only exceptions are an Epi-pen or Inhaler.
- All medications must be brought to the school by the parent or legal guardian.
- An authorization form (this form) must be completed and signed by the parent and physician and on file in the nurse office.
- Any over-the-counter medicine other than what the school is authorized to give, must be provided by the parent or legal guardian and brought to the school in the original medication container.
- Any prescription medications must be brought to the school in the original bottle properly labeled by the pharmacist as prescribed by law.

Student Name: ____ Grade: _________________

Date of Birth: ______________________ Age: _____________ Teacher: _______________________

TO BE COMPLETED BY PHYSICIAN:

Name of medication, dosage, and route: ____

Time to be taken at school _________________________ Duration of Medication ________________________

Purpose of the medication ____

Possible side effects or adverse reactions ____

Are there any restrictions ( ) yes ( ) no; if yes, what and for how long? ____________________________________

_______________________________ ____________________________________ ________________

(Printed name of Physician) (Signature of Physician) (Date)

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

I request that my child (named above) receive:

_____ Over-the-counter medication *provided by me and approved by the physician as documented above.*

_____Medication prescribed by the physician as documented above.

I, _________________________________ give permission for my child, _________________________________ to receive the medication listed above as directed during school hours. I understand that the school nurse will administer or observe my child taking this medication. In the nurse's absence, I understand that the principal or other trained non-medical school personnel will administer or observe my child taking this medication.

_____________________________________ _______________________ _______________________

(Parent /Guardian Signature) (Phone Number) (Date)