

**HAMBLÉN COUNTY SCHOOLS
PRESCRIPTION MEDICATION INFORMATION**

DIRECTIONS FOR PARENT/GUARDIAN:

The following is to be filled out and signed by both the parent/guardian and the physician prescribing medication for your child. No medication of any kind can be given to your child until this information is completed and returned to the school. Please remember that all medication must be in a container labeled by a pharmacy. If any changes in medication occur during the school year, a new form must be filled out and returned to the school. Use only one form for each medication.

The parent/guardian signature on this form constitutes consent to the administration of the medication described on this form. It is understood that the person giving the medication and/or assisting in the self-administration of medication may not be a medically-trained person. By signing, the parent/guardian releases the Hamblen County Board of Education, its agents and its employees from any and all liability in the administration of this medication. **Please do not send medication by children. Medication must be brought to school and picked up by a responsible adult.**

Child's name _____ Date of birth _____

Physician's name _____

Address _____ Phone _____

Name of medication _____

Is refrigeration necessary? _____

Reason for medication _____

Dosage to be given _____ Method/Route _____

Time of day medication to be given _____

Reason for necessity of giving medication during school hours _____

Possible side effects and procedures to follow _____

List any special instructions _____

List any known allergies _____

THIS FORM IS GOOD FOR ONE SCHOOL YEAR ONLY. If this order for medication expires before the end of the school year, please specify the expiration date _____

By signing below, I give permission for the school officials to contact the physician regarding the above medication.

PHYSICIANS' SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

EMERGENCY/PARENT'S PHONE NUMBER _____