Houston County School District

Health Related Services

HEALTH RELATED SERVICES REQUEST
for ASSISTIVE ADMINISTRATION of MEDICATION

If this form is properly completed and returned to the school, the Houston County School System may assist students in taking their medication during school hours.

- **The medication will only be given if it is delivered in the original bottle marked with the student's name, dosage, time of administration, physician, pharmacy, and date of purchase.**
- **Parent/guardian must provide specific instructions, as well as the medication and related equipment.**
- **It is 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.**
- **All medication will be taken directly to the office by the parent.**
- **Unused medication will be disposed of unless picked up within one week after medication is discontinued, or at the end of the school year.**
- **A new medication request must be provided to the school each school year and with each new medication.**

Name of Student: _____ Birthdate: _____ Student ID#:_____
School: _____Grade: _____
Allergies: _____

STATEMENT OF PARENT/GUARDIAN

As parent/guardian (*circle one*) of the above name student, I do hereby request the school system give medicine to the above named student. I understand that the school system is not legally obligated to administer medication except to a student whose disabling condition requires the administration of medication in order to benefit from his/her educational program and who is afforded accommodations under applicable federal law. I understand that school personnel will administer the medication in accordance with the policy and procedures of the school system.
I consent to the release of medication information by and to my child's physician and/or pharmacist as needed.

_____	_____	_____	_____
Signature of Parent/Guardian	Date	Home Phone	Work Phone

----------Below to be completed by physician----------

Student's Diagnosis:_____

Scope: This medication must be given **during** school between 7:00 a.m. - 3:30 p.m.

Medication: _____

Dose_____ Route_____ Time/Frequency_____

Possible medication side effects _____

☐ This student **is** competent in the use of and can carry their **emergency** medication listed above on their person at all times.

Physician's Signature _____ Date:_____

Physician's Name _____ Physician's Phone _____

NPI #_____

School Nurse Signature_____ Date:_____

(478) 988-6200, Ext.3554

HOUSTON COUNTY BOARD OF EDUCATION
HIGH-ACHIEVING STUDENTS

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