FANNIN COUNTY BOARD OF EDUCATION

Fannin County Schools Staff Development Center
6145 Old Highway 76 Blue
Ridge, Georgia 30513
Phone: 706-632-3771 Fax: 706-632-7583
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Authorization to Give Medication at School

If medication can be given at home or after school hours, please do so. However, if medication **must** begiven during school hours, all medications must be taken by the student, parent or guardian to the school office immediately upon arrival at school and must be in original pharmaceutical containers, clearly labeled as to the name of the student, the name of the medication, the appropriate dosage, and the times for dosage. We prefer parent/guardian to bring medication to the clinic instead of the student to ensure all paperwork and expectations are thoroughly discussed.

Student's Name: _____

Teacher: _____ **Grade:** _____

I hereby request that _____ School, through the principal or designee; supervise/assist in the administering of medication to my child, according to the instructions contained on the statements below. I understand that:

- All Medications **must** be in the **original labeled** bottle/container (no baggies, foil, or opened containers, etc.). This includes all over the counter medications as well.
- 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/container 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.

_____ _____
Parent/ Legal Guardian Signature **Date**

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

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To be completed by healthcare provider for all medication(s) required for **20 days or more.**

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any: _____

Signature of Healthcare Provider _____ Date _____