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
www.fannin.k12.ga.us

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, an adult must bring medication to appropriate school personnel and complete this form. Students may **NOT** transport medications to/from school;
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 tothe principal or clinic personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medicationor new doses will not be given unless a new form is completed and a newly labeled bottle/container is provided.
- All medication will be taken directly to the office/clinic by the parent/guardian.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

****

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:** _____ **Pager/Cell Phone:** _____

****

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

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any: _____

_____

_____ _____
Signature of Healthcare Provider Date