STEWART COUNTY SCHOOL SYSTEM
AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

STUDENT'S NAME: _____

TEACHER: _____ GRADE: _____

I request that the Stewart County School System, through the principal or designee, supervise/assist in the administering of medication to my child according to instructions in the statements below. I understand that:

- Medications must be in the **original labeled container** (no baggies, foil, etc.). Pharmacists can provide a duplicate labeled container with only the school doses.
- 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 container is provided.
- All medication will be taken directly to the office/clinic by the parent. Medication is not allowed to be brought to school on the bus.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

Name of Medication: _____

Dose_____ **Route (by mouth, topical, etc.)**_____

Time(s) to be given_____

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any: _____

Healthcare Provider's Name: _____ **Phone:** _____

I hereby authorize the personnel, employees and officials of the Stewart County School System to assist my child in taking prescribed medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

_____ _____

Parent/ Legal Guardian Signature Date

Home Phone: _____ Work Phone: _____ Pager/Cell Phone: _____
