Atkinson County School Nurses' Office

Authorization To Give Medication At School

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed. Please write one medication per page.

Student's Name: _____

Teacher: _____Grade:_____

I request that _____ School, through the principal or designee supervise/assist in the administrating of medication to my child, according to the instructions 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/legal guardian.
- 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: _____Stop Medication on: _____

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any:_____

Physician's Name: _____Physician's Phone:_____

I hereby authorize the personnel, employees and officials of the _____School District to assist my child in taking prescribed medication according to district policy and I release them from any liability for administering this 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_____Pager/Cell_____

To be completed by School Health Clinic Personnel only:

Date received: _____ Name of Medication:_____#Doses: _____