WALTON COUNTY PUBLIC SCHOOLS

Authorization to Give Medication at School

Student Name: _____

Date of Birth: _____

Grade: _____ Teacher: _____

Name of Parent/Guardian: _____

- I understand that the School Nurse will administer, or supervise/assist in the administration of, medication to my child according to the instructions listed below.
- I understand that medications must be in the original labeled container (no baggies, foil, etc.) (Note: Pharmacist can provide a duplicate labeled container with only the school dosage.)
- I understand that a parent/guardian must provide specific instructions as well as the medication and related equipment to the Principal or Clinic personnel.
- I understand that it is the responsibility of the parent/guardian to inform the school of any changes in medication, doses, time of administration, etc. 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 Clinic/Office by the parent/guardian.
- Unused medication will be disposed of unless picked up by the parent/guardian within one (1) 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 School Nurse, and other personnel as authorized, to assist my child in taking prescribed medication according to Board Policy JGCD and JGCD-R. I hereby release, and covenant not to sue, the Walton County School District, and its employees, from liability in connection with any claims arising out of the administration of medication.

Parent/Legal Guardian signature: _____ Date: _____

TO BE COMPLETED BY SCHOOL HEALTH CLINIC PERSONNEL ONLY:

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

"TO BE COMPLETED BY HEATHCARE PROVIDER FOR PRESCRIPTION GIVEN FOR MORE THAN TWO WEEKS"

Conditions/Illness Requiring Medication: _____

Possible Side Effects if any: _____

Signature of Healthcare Provider _____ Date: _____

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