

**COLUMBIA COUNTY SCHOOL SYSTEM
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.

STUDENT'S NAME: _____

TEACHER/GRADE: _____

I hereby request that the Columbia County School System, through the principal or designee, supervise/assist in the administering of medication to my child, _____, according to the instructions contained on the statement below.

I understand that:

- Medications must be in the original labeled container (no baggies, envelopes, foil, etc.).
- 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.
- The student will take all medication directly to the office/clinic upon immediate arrival if he/she is transporting medication.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.
- If this is an "as needed" medication, medication will not be administered until I can be reached by phone each time my child is requesting this medication. I understand that this is for my child's safety to prevent accidental overdose either at home or at school.

NAME OF MEDICATION: _____

DOSAGE/TIME OF ADMINISTRATION: _____

START/STOP MEDICATION ON: _____

PHYSICIAN'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 PHYSICIAN IF MEDICATION IS TO BE ADMINISTERED GREATER THAN TEN DAYS.

CONDITION/ILLNESS REQUIRING MEDICATION: _____

POSSIBLE SIDE EFFECTS, IF ANY: _____

SIGNATURE OF PHYSICIAN : _____

DATE: _____