

**Newton County Schools**

**Authorization To Give Medication At School (Prolonged Time Period)**

**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, nurse or designee supervise/assist in the administering of medication to my child according to instructions the instructions below.

I understand that:

- Medications must be in the original labeled container (no baggies foil, etc.) Pharmacies can provide a duplicate labeled container with only the school doses.
- Parent/guardian must provide special 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 medications or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- All medications 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.

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Name of medication: \_\_\_\_\_

Dose: \_\_\_\_\_ Route (by mouth, topical, etc.): \_\_\_\_\_

Time(s) to be given: \_\_\_\_\_ Stop Medication on: \_\_\_\_\_

Physicians Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

I hereby authorize the school 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 Phone \_\_\_\_\_ Pager/Cell Phone \_\_\_\_\_

Condition/Illness Requiring Medication: \_\_\_\_\_

Possible Side Effects if any: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Healthcare Provider**

\_\_\_\_\_  
**Date**