

 Troup County School System Health Services

 **AUTHORIZATION TO GIVE MEDICATION AT SCHOOL**

 **PARENT MUST SUPPLY MEDICATION TO BE STORED AT SCHOOL**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Permission Form**

This form must be completed if medication has to be administered during school hours, on field trips or during a school chaperoned “before” or “after” school activity. Please give all medications at home before or after school hours when possible as some medication may not need to be given during school hours.

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_ School Year \_\_\_\_\_\_\_

Homeroom Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the following:

* Medications (both prescription and non-prescription) must be in the original labeled container and must match the instructions below.
* The parent/guardian is responsible for assuring the school receives specific instructions regarding medication usage, including the medication and related equipment.
* The parent/guardian is responsible for informing the school of any changes with the medication. New medications or new doses WILL NOT be given until a new form is completed.
* All medication should be taken directly to the school office/clinic by the parent.
* All unused or discontinued medication will be properly disposed of at the end of the school year if not picked up prior to or on the last day of school. Medications that have been discontinued must be picked up within one week or will be properly disposed of by the clinic.
* Trained staff assist students with medication administration. However, school employees will not assume any liability for supervising or assisting in the administration of medication (including choking, allergic reactions, side effects and/or any health risk related to this medication.
* **Completion of this form for prescription medication authorizes TCSS-Health Services Dept. to discuss the medication order/request with the prescribing healthcare provider if indicated and/or needed.**

Permission is hereby granted to the annually trained unlicensed assistive personnel or the school nurse to assist with administration of medication to my child as indicated below. I release Troup County School System and any Troup County School System employee from any liability associated with administering this medication. **Parent/Guardian authorization signature is needed for both prescription and non-prescription medications.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Legal Guardian Signature Print Name Legibly Date

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ONE MEDICATON PER FORM

|  |  |
| --- | --- |
| Medication Name:  | Prescribed Dosage: |
| Possible Side Effects: | Route, Time and other Instructions |
| Diagnosis/Condition/Illness Requiring Medication: |

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number \_\_\_\_\_\_\_\_\_\_\_\_

This Section to be completed by School Nurse/Clinic Assistant for refills/pick up of medication

|  |  |  |
| --- | --- | --- |
| Date | Medication Name | # of Doses |
| Expiration Date | Completed by | Parent/Guardian Signature   |

**Refills**

|  |  |  |
| --- | --- | --- |
| Date | # of Doses | Rec’d by |
| Date | # of Doses | Rec’d by |