Authorization to Give Medication at School
DeKalb County School System
School Year 20____ to 20____

If medication can be given at home or after school hours, please do so. However, if medication must be given during the school hours, this form must be completed.

Student's Name: _____ **Date of Birth** _____

Teacher: _____ **Grade:** _____

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

- Medications must be in the original labeled container (no baggies, foil, etc.).
- Parent/guardian must provide specific instructions, as well as the medication and related equipment for use 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.
- All medication will be taken directly to the office /clinic by the parent.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

To be completed by Physician for Medication Administration at School

Name of Medication: _____

Dosage and Time of Administration: _____

Route of Administration _____ **Stop Medication on:** _____

Condition/Illness requiring medication: _____

Possible side effects, if any: _____

Physician's Name (print): _____ **Physician's phone:** _____

_____ **Date:** _____
Signature of Physician Licensed to Prescribe

I release the school board, the school, and any school employee from any liability for administering this medication.

_____ **Date:** _____
Parent/Legal Guardian Signature

Home Phone: _____ **Work Phone:** _____ **Pager/Cell Phone** _____

DeKalb County School System

School Health Program/Student Section 504 Authorization for Student to Carry Prescription Inhaler, Epi-Pen, or Insulin

Dawson needs to carry the following prescription inhaler, Epi-Pen, or insulin with her. The above-named student has been instructed in the proper use of the medication and fully understands how to administer this medication. (It is preferable that a second prescription labeled inhaler, Epi-Pen, or additional insulin be kept in the clinic in case the first is lost or left at home.)

Medication	Dosage and Directions	
Physician's Stamp	Physician's Signature	Date

I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the priviilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the clinic assistant to keep her informed of the use of my medication in case I start having problems.

Student's Name	Student's Signature	Date

I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above while at school. I accept legal responsibility should the above be lost, given, or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the DeKalb County School System and its employees of any legal responsibility when the above named student administers her own medication.

Parent/Guardian's Name	Parent/Guardian's Signature	Date

PARENT AND PHYSICIAN AUTHORIZATION FOR USE OF NON-PRESCRIPTION MEDICATION AT SCHOOL

DeKalb County School System

School Year 20____ to 20____

STUDENT_____DATE OF BIRTH_____

SCHOOL_____DATE_____

All non-prescription (over-the-counter) medication must be approved by the parent/guardian *and* the student's physician in order to be given at school. Listed below are some of the non-prescription medications that might be needed during the school year. ***This form must be signed by the child's physician in order for these medications to be given at school.***

		Dosage (please complete)
Allergic Reaction	Benadryl Syrup	_____
Fever/Pain	Tylenol Syrup	_____
Fever/Pain	Ibuprofen	_____
Skin Abrasions	Polysporin Ointment	_____
Dry skin/lips	Vaseline	_____
Diaper rash	Desitin	_____

If you would like to delete any of these non-prescription medications, please do so by drawing a line through that medication. List any additional non-prescription medications, with dosage, below and send medication to school with an adult.

_____

_____

_____

_____ _____

Signature of Practitioner Licensed to Prescribe **Date**

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I release the school board, the school, and any school employee from any liability for administering this medication. **Parents must supply all non-prescription medications.** Medications will be given only if needed. An attempt will be made to notify the parent before an over-the-counter medication is given.

_____ _____

Parent Signature **Date**