AUTHORIZATION TO GIVE MEDICATION

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 NAME: _____

TEACHER: _____ GRADE:_____

I request that Cartersville City Schools, through the principal or nurse, supervise/assist in the administering of medication to my child, according to instructions in the statements below. I understand that:

- Medications must be in the original container (no baggies, foil, etc.). Pharmacists can provide a duplicate labeled container with only the school doses.
- 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 and a newly labeled container is provided.
- 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.

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: _____

Healthcare Provider's Name: _____ Phone: _____

I hereby authorize the personnel, employees and officials of Cartersville City Schools to assist my child in taking prescribed medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form. I authorize the prescribing physician to discuss with the principal or school nurse any matter regarding the medication to be administered.

_____ _____

Parent/Legal Guardian Signature Date

Cell Phone: _____ Work Phone: _____ Home Phone:_____