**SOCIAL CIRCLE CITY SCHOOLS**
147 ALCOVA DRIVE
SOCIAL CIRCLE, GEORGIA 30025
770-464-2731

# 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. Please write one medication per page.**

**Student's Name:** ____________________________________________________________

**Teacher:** ________________________________________ **Grade:** __________________

I request that ___________________________School, through the principal or designee supervise/assist in the administering of medication to my child, according to the instructions below. I understand that:

- Medications must be in the original labeled 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/legal 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: _________________________

Condition/Illness Requiring Medication: ___________________________________________________

Possible Side Effects, if any: ____________________________________________________________

Physician's Name: ____________________________ Physician's Phone: _________________________

I hereby authorize the 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 ___________________________

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*To be completed by School Health Clinic Personnel only:*

Date received: ___________ Name of Medication: ____________________________ # Doses: ______________