Student Health Services

AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

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: _____ **DOB:** _____ **School Year:** _____

Homeroom Teacher: _____ **Grade:** _____ **Known Allergies:** _____

I hereby request Pickens County School System, through the Principal or designee, to supervise/assist with administering this medication to my child, according to the instructions contained in the statement below and in accordance with Pickens County Schools Medication Policy. 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/legal guardian is responsible for assuring the school receives specific instructions regarding medication usage, including the medication and related equipment.
- The parent/legal 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 or legal guardian.
- 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 (to include choking, allergic reactions, side effects and/or any health risks related to this medication).
- **Completion of this form for prescription medication authorizes Student Health Services to discuss the medication order/request with the prescribing healthcare provider if indicated and/or needed.**

I release Pickens County School System and any Pickens County School System employee from any liability associated with administering this medication. **Parent/Legal 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 MEDICATION PER FORM - *SUBMIT FORM TO THE SCHOOL CLINIC*

NON-PRESCRIPTION MEDICATION / OVER-THE-COUNTER MEDICATION

Medication Name:		Diagnosis/Condition/Illness Requiring Medication:
Start Date:	Stop Date:	Dosage, Route and Time(s) of Administration:

PRESCRIPTION MEDICATION

Medication Name:	Prescribed Dosage:
Possible Side Effects:	Route, Time and Other Special Instructions of Administration:
Diagnosis/Condition/Illness Requiring Medication:	

_____ _____ _____

PRINT PHYSICIAN NAME LEGIBLY PHYSICIAN/OFFICE CONTACT NUMBER DATE

This Section to be completed by School Nurse or designated personnel ONLY

Date Received:	Medication Name:	# of Doses:
Expiration Date:	Completed by:	Date Returned to Legal Guardian:

Medication Count Form

Student Name:	
Medication Name:	Medication Dose:

Date:	Amount Remaining:	Nurse Signature	Witness Signature	Amount Delivered: (if applicable)	Parent/Guardian Signature (if applicable)

"Amount Delivered" Count should be completed whenever new medication is brought to clinic

"Amouth Remaining" Count should be completed and witnessed twice a week for all controlled substances