AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

Jackson County School System

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 complete. Please write one medication per page.

Student's Name: _____ School Year: 20___ - 20___

I request that the clinic assistant or unlicensed school health personnel supervise/assist in administering medication to my child according to the instructions below.

*****Medication must be in the original labeled container (no baggies, foil, etc.). Pharmacies can provide a duplicate labeled container for doses that are given during school hours.

*****Parent/guardian must provide special instructions, as well as the medication.

*****The parent/guardian is responsible for informing the school of any medication changes (dose/time, etc) and providing the school with a new signed authorization form and newly labeled container.

*****Medication should be picked up and dropped off by the parent/guardian through the front office or clinic.

*****Unused medication will be disposed of unless picked up by the end of the last day of the current school calendar year. No medication will remain on campus or be kept for the next school year.

*****If you are requesting an OTC (over the counter) medication (ibuprofen, cough syrup, etc) be given on a daily basis to your child for more than a week, we will require a physician's order /signature.

Name of medication: _____

Dose: _____ Route**:** (by mouth, eye drops, ear drops, etc.) _____

Time(s) to be given: _____

I hear by authorize the school personnel to assist my child in taking medication and release them from any liability for administering this medication. I understand that the parent/guardian is responsible for making sure the school has the prescribed medication available to administer and it is not the schools responsibility to notify the parent/guardian when no medication is available.

Parent/Guardian Signature: _____ Date: _____

Phone: _____