

PARENT/GUARDIAN MEDICATION PERMISSION FORM

(This form must be completed before a parent-prescribed, self-prescribed, or doctor-prescribed medication can be taken by a student at school.)

Dear Parent/Guardian,

The school has received a request from you that _____ is taking medication and will need to take it during school hours. We request that you fill out this form for your child and keep us updated on medication dosage and/or treatment changes.

We also ask for your assistance in helping us with the large amount of medication that is being taken by students during school hours. We request that if the medication can be taken at home instead of during school hours that the parent/guardian be encouraged to do so.

Medication will only be given if it is **delivered to the school in the original bottle**, marked with the student's name, dosage, the time to be administered, Health Care Provider name, pharmacy name, and date of purchase. Parents must deliver medication to the school. For safety reasons, do not send medications in student book bags. Please read the reverse side of this form.

Your assistance with this is greatly appreciated. Thank you.

Student's Name: _____	Birthdate: _____	Grade: _____	School: _____
Illness requiring medication: _____			
Name of medication to be given to this student: _____			
Dosage to be given: _____		Time to be given/directions: _____	
Route to be given: _____		How many days is medicine to be given?: _____	

Prescribing Health Care Provider's (Doctor, Dentist, etc.) Name: _____

Address: _____ Health Care Provider's Phone #: _____

List possible (significant) side effects of this medication: _____

Allergies of student: _____

Other Information / Comments: _____

STATEMENT OF PARENT/GUARDIAN

I hereby release and discharge the Hall County Board of Education, the Hall County Board of Health, and its employees and officials, from any and all liability in case of accident or any other mishap in supervising/assisting with said medication due to any side effects, illness, or other injury which might occur to my child through supervising/assisting with said medication, and I hereby release said aforementioned officials from any liability because of any injury or damage that might occur.

Permission is hereby granted to the principal or his/her designee to supervise/assist my child in taking the indicated medication. I understand that a concerted, reasonable effort will be made to administer the medication listed above. (See reverse side for guidelines for all medication administration.)

I give the above mentioned personnel permission to contact my child's health care provider, if necessary, to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required. For lifesaving emergency medications, I give permission for school staff on a "need to know" basis be trained on administration of this medication for my child.

Signature of Parent/Guardian

Date

Work Phone #: _____ Home Phone #: _____

Cell Phone #: _____