Barrow County School System Medication Authorization

Student's Name_____**Birth Date**_____ **Drug Allergies**_____

School_____**School Year**_____

Grade_____ **Teacher (If applicable)** _____

Please note the following:

1. All medications, whether *prescription* or *over the counter* must be in the **original labeled container** (no baggies or foil).
2. A parental note **cannot** override the labeled directions for prescription or over-the-counter medication.
3. Parent / guardian must provide specific instructions, as well as the medication and related equipment to the principal or clinic personnel.
4. It is the responsibility of the parent / guardian to inform the school of any changes. If there is a change in prescription doses either a new labeled container or a signed note from the prescribing physician must be provided.
5. All medication will be taken directly to the office / clinic.
6. Unused medication will be disposed of unless picked up within one week after medication is discontinued.
7. The school will contact the prescribing physician or dispensing pharmacy as needed regarding prescribed medicines.
8. It is the responsibility of the parent / guardian to ensure that all the medication in the container arrives to school.
9. **Prescribed medication – a Physician's order/prescription is required. (On original labeled container)**
10. **Over-the-Counter medication – medications will only be given for 3 consecutive days and not exceed 7 calendar days unless specified order/prescription given by a Physician**.

Name of Medication_____ Is this a prescription medication? YES NO

Dosage and Time of Administration_____
(Note: If different from labeled directions the school will not give the medications)

Number of Pills in Container_____ **Stop medication on**_____ **Expiration Date**_____

Reason for Medication_____

Physician's name: _____ Phone Number_____

Physician's Signature: _____ Date: _____

I hereby request that the Barrow County School System, through the principal or designee, supervise / assist in the administration of medication to my child, named above, and according to the instructions contained in the statements above. I release the school board, the school, and any school employee from any liability for administering this medication. This permission must be renewed annually for medications that are needed on a continuous basis.

_____

Parent / Guardian Signature **Phone Number** **Date**

Date_____ #Pills_____Meds brought by_____ Date_____#Pills_____ Meds Brought by_____

Date_____ #Pills_____Meds brought by_____ Date_____#Pills_____ Meds Brought by_____

Date_____ #Pills_____Meds brought by_____ Date_____#Pills_____ Meds Brought by_____

Date_____ #Pills_____Meds brought by_____ Date_____#Pills_____ Meds Brought by_____

Medication picked up by_____ Date_____