WALTON COUNTY PUBLIC SCHOOLS

Authorization to Give Medication at School

Student Name: _____

Date of Birth: _____

Grade: _____ Teacher: _____

Name of Parent/Guardian: _____

- I understand that the School Nurse will administer, or supervise/assist in the administration of, medication to my child according to the instructions listed below.
- I understand that medications must be in the original labeled container (no baggies, foil, etc.) (Note: Pharmacist can provide a duplicate labeled container with only the school dosage.)
- I understand that a parent/guardian must provide specific instructions as well as the medication and related equipment to the Principal or Clinic personnel.
- I understand that it is the responsibility of the parent/guardian to inform the school of any changes in medication, doses, time of administration, etc. 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 Clinic/Office by the parent/guardian.
- Unused medication will be disposed of unless picked up by the parent/guardian within one (1) week after medication is discontinued.

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 School Nurse, and other personnel as authorized, to assist my child in taking prescribed medication according to Board Policy JGCD and JGCD-R. I hereby release, and covenant not to sue, the Walton County School District, and its employees, from liability in connection with any claims arising out of the administration of medication.

Parent/Legal Guardian signature: _____ Date: _____

TO BE COMPLETED BY SCHOOL HEALTH CLINIC PERSONNEL ONLY:

Date received: _____ Name of medication: _____ # Doses: _____

****TO BE COMPLETED BY HEATHCARE PROVIDER FOR PRESCRIPTION GIVEN FOR MORE THAN TWO WEEKS****

Conditions/Illness Requiring Medication:_____

Possible Side Effects if any:_____

Signature of Healthcare Provider_____ Date: _____

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WALTON COUNTY PUBLIC SCHOOLS

Authorization for Administration of Emergency Medications by Unlicensed Personnel

Student Name: _____

Parent/Guardian: _____

Date of Birth: _____ School: _____

There may be times when the school nurse is not present on campus, or is otherwise unable to respond, to an emergency which requires the administration of medication. In that event, in accordance with Board Policy JGCD and JGCD-R, parents have two options regarding the emergency administration of medication.

Under the first option, parents have the option to delegate the administration of emergency medication to the school Principal who will then designate an unlicensed school employee, who has been trained, to administer the emergency medication in the event the school nurse is unavailable to do so. Under the second option, parents may limit their authorization so that emergency medications may be administered only by the school nurse.

This form is to be completed by parents who are delegating the administration of emergency medication to the school principal and authorizing unlicensed personnel to administer certain medications in the event of an emergency. Parents completing this form are authorizing someone other than the school nurse to administer certain emergency medications their child.

I hereby delegate to the school Principal the task of designating certain staff members, who have been trained in accordance with Georgia law, State Board of Education rules and/or Policy JGCD and JGCD-R, to administer medication to my child in accordance with Physician's Orders. I hereby release, and covenant not to sue, the Walton County School District, and its employees, from liability in connection with any claims arising out of the emergency administration of medication.

I further agree to notify the school nurse of any changes in my child's health condition and/or medication regimen.

_____

Parent/Guardian Signature Date