

Marietta City Schools Assistance with Medication/Procedure

Student Information

Student's First Name: _____ Student's Last Name: _____
 Age: _____ Date of Birth: _____
 School _____ Teacher _____ Grade _____
 Parent Name: _____ Parent Phone: _____
 Name of Medication/Procedure _____
 Dose: _____ Scheduled: PRN:
 Time: _____ Route (oral, injection, etc.) _____
 This request is valid from (dates): _____ to _____

Medical Information*

****This section to be completed by licensed medical provider for all prescription medications.***

Possible side effects/comments: _____
 Goal: _____

Vision and Hearing Screening to be included in plan of care

Provider's Name (print): _____
 Provider's Signature: _____ Date _____

Provider's Phone: _____

Provider's Address: _____

Provider's NPI Number: _____

******Prescription medication must be in the original container from the pharmacy. Only the instructions for dosage and times for administration written on the container or received from the physician/provider will be followed. All prescription medications require physician/provider signature. All OTC medications given for more than 10 consecutive days will require physician/provider signature. Parents are responsible for personally collecting from school any unused portion of medication within one week after expiration of the medication and/or physician's order. Medication that is not personally collected by the parent/guardian will be destroyed.***

Parental Authorization*

****This portion to be completed by the authorizing parent/guardian***

I authorize the personnel of Marietta City School District to assist my child in taking medication. I hereby release and waive, and further agree to indemnify, hold harmless or reimburse Marietta City Schools, the individual members, agents, employees and representatives thereof, from and against, any claim which I, any other parent or guardian, any sibling, the student, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, for any losses, damages or injuries arising out of, during or in connection with the administration of this medication/procedure.

Signature of parent/guardian _____ Date _____

My child receives Medicaid/PeachCare for Kids. I understand that the school system can file with Medicaid for partial reimbursement for the administration of this medication/procedure and I do hereby authorize the school system to bill for the services above. If I decide I no longer want the school to bill Medicaid, I understand that I must notify the school in writing.

Signature of parent/guardian _____ Date _____