



School Nurse Clinic Authorization of Medication Administration

A signed updated authorization of medication administration form from the parent or guardian giving permission must be on file with the School Nurse at all times. Medication shall be given by the school nurse but arrangements must be made in advance of when the medicine needs to be given. Prescription medication will be dispensed and it must be in the original bottle, labeled properly and dated. For children who take medicine regularly – we will try to keep you informed when our supply is running low but please keep in mind that it is up to the parents to know when the medicine will run out and send more. Also, please make doctor appointments well in advance of running out of medication. If dosages change, a new form must be filled out before the medicine can be given to the child.

Whenever possible, please encourage medication to be taken at home before school or promptly after school. If this is not possible, then we want to see to the needs of your child, but we need your cooperation in securing adequate records for the safety of your child. Keep in mind also, over the counter (OTC) medications will be considered on an individual basis but a written order by a physician is preferred. If the student is covered under a Medicaid plan, this form will give the school permission to bill Medicaid for the services rendered during school hours. If at any time a parent/guardian requests that Medicaid billing be discontinued, the request must be submitted in writing. With changes in IDEA, consent for billing will be obtained at each service change planning time.

DO NOT TRANSPORT MEDICATION WITH STUDENTS!!

Please fill out the information below giving the school permission to give the medication and release the school and the nurse of any adverse reactions that may occur as a result of taking this medication.
Return it to the school as soon as possible with the prescribed medication.

Child's Name _____ Teacher _____

Physician's Name _____ Date _____

Physician's Phone Number _____ Fax Number _____

Name and dosage of medication _____

Time(s) medication is to be given at school _____

Duration _____ Start Date _____ Stop Date 7/31/2025 or _____

Time and dosage medication is given at home _____

Type of Insurance: Blue Cross/Blue Shield _____ Medicaid _____ State Merit _____ Peach Care _____ Other _____

Parent/Guardian Signature _____

Emergency contact phone numbers _____

***Only fill out the following forms if your child is on Medicaid/Peachcare ***



EXCEPTIONAL STUDENT DEPARTMENT

Parental / Guardian Consent Form For Medicaid and/or Peachcare

◆ PLEASE PRINT ALL FIELDS ◆

Name of Student: _____ Date of Birth: _____
Last Name Legal First Name

SS#: _____
Student's Social Security Number

Parent/Guardian: _____ Relationship to Child: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Dr. Name (Student's physician): _____

Dr. Phone Number: _____

Dr. Address: _____ City: _____

Reimbursement for services does require that a form be completed by your child's physician. Once you provide the contact information requested on this consent form, a document will be sent to the physician for completion. Your selection and signature gives or denies your permission for the School System to provide pertinent information to services provided in the student's IEP to their physician as required by Medicaid.

The School System is providing the health-related services to your child in accordance with his/her Individual Education Program or Individual Family Service Plan. Medicaid and/or PeachCare is required to cover some of the cost of certain services.

The School System cannot bill Medicaid/PeachCare without your consent. If you allow the school system to bill Medicaid or PeachCare for the health-related services that your child is receiving in accordance with his/her Individual Education Program or Individual Family Service Plan, check the "Yes" box and sign below.

Your selection and signature (parent/guardian) gives or denies permission to the school to bill Medicaid/PeachCare for the frequencies of services as defined in your child's IEP or IFSP beginning with the current school year.

- YES I authorize the School System to bill Medicaid and/or PeachCare for the health related services listed in my child's IEP or IFSP.
- NO I do not want Medicaid and/or PeachCare billed for health related services my child is receiving.
- My child does not currently receive Medicaid; however, if he or she were in the future, I give THOMAS COUNTY SCHOOLS permission to bill for services.

Parent/Guardian Signatures: _____ Date: _____

It is my responsibility as a parent to notify the school system's Special Education Department in writing if I ever decide to withdraw this consent allowing the school to seek reimbursement from Medicaid/PeachCare.

Note: As of April 1, 2003, the Children Intervention Services Program (CIS) and the Children Intervention Service Program (CISS) have been separated. Students can receive medical services in both programs without impacting service limitations.

If you have any questions, please call: Carol Sprague, Director of Exceptional Students (229-225-4380)



EXCEPTIONAL STUDENT DEPARTMENT

Service Plan for School Based Medicaid Services

[Please Print]

Parent/Guardian SECTION

STUDENT NAME: _____ DOB: ____/____/____ M F

ADDRESS: _____ City _____ GA ZIP: _____

SCHOOL: _____

SS# _____ My child is receiving Special Ed. Services _____ Nursing is in
the IEP

PARENT/GUARDIAN: _____ HOME #: _____ As the parent / legal guardian of the student named above I expressly authorize and give permission to Thomas County Schools to have the designated person administer the above prescribed medication/treatment to my child. I agree that the school system and its employees shall not be liable or responsible, and shall be indemnified and held harmless for any illness or damage to any person or property which may result from the storage of medication, from giving our child medication/treatment, or from failing to give our child medication/treatment.

My child is eligible for MEDICAID OR PEACHCARE YES NO. Number _____ I understand that the school system is able to file with Medicaid or Peachcare for partial reimbursement for the administering of this medication or procedure. I wish the school system to receive this payment from Medicaid or Peachcare.

I have read this form and understand my responsibility toward the school, which is agreeing to assist me in this matter of medicating/treating my child at school. I may change / withdraw permission in writing at any time by notifying the Special Education Director.

The undersigned authorizes the prescribing physician named below to release any information to the School Board or their designee regarding the medication/treatment to be administered. I, the undersigned, authorize THOMAS COUNTY SCHOOLS to release pertinent information to the physician.

Signature of Parent / Guardian Living with Student Date

Physicians – Please complete ALL items

And return as expeditiously as possible.
Fax to: Exceptional Students Department (229)225-5234

The following medication/treatment as listed should be dispensed at school as indicated:

Medication/Treatment: _____

Diagnosis: _____

GOAL OF THIS REGIMEN OF MED./Treat. Improve Attention Span Reduce Impulsiveness Improve School Performance Control Blood Sugar Level Control Seizure Activity Prevent Respiratory Distress

Other please specify: _____

Rehabilitative Potential _____

DURATION OF MED. /Treat.: SCHOOLTERM Indefinitely OTHER _____

Time med. /treat. is to be given at school: 7:30- 8:30 a.m. 11:00 a.m. – 12:30 p.m. Other _____ PRN

Physician's Signature original – DATE

Physician's PHONE

Please Print Physician's Name

ADDRESS _____