COWETA CHARTER ACADEMY

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Authorization to Give Medication at School

If medication must be given during school hours, this form must be completed. Please write ONE medication per page.

Student's Name_____ **Teacher/Grade:** _____

I request that Coweta Charter Academy, through the school nurse or designated clinic attendant supervise/assist in the administering of medication to my child, according to the instructions below. I understand that:

• Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacists can provide a duplicate labeled container with only the school doses. The name on the prescription label MUST match the student's name in Infinite Campus.

• Parent/guardian must provide specific instructions, as well as the medication and related equipment (for example, a spacer if needed for an inhaler) to the clinic personnel.

• It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or dosage changes will not be given unless a new form is completed, and a newly labeled container is provided.

• All medication must be taken directly to the front office or the clinic by the parent/guardian, do NOT send in your child's book bag.

• Unused medication will be disposed of unless picked up within one week after medication is discontinued, or at the end of the school year for daily or "as needed" medications not picked up during the last week of school.

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Medicine Name: _____Dose: _____

Route (by mouth, topical, etc): _____ Time(s) to be given: _____

Stop Date (if applicable)_____

Condition/Illness Requiring Medication:_____

Physician's Name: _____ Physician's Phone:_____

I hereby authorize the personnel, employees and officials of Coweta Charter Academy to assist my child in taking the above prescribed medication and I release them from any liability for administering this medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new Medication Authorization Form.

_____ _____

Parent/ Legal Guardian signature **Date**

Primary Phone Number: _____ Secondary Phone Number: _____

To be completed by School Health Clinic Personnel only:

Name of Medication: _____ # Doses: _____

Date Received: _____ Received By: _____