

WALTON COUNTY SCHOOL SYSTEM REQUEST FOR ADMINISTRATION OF MEDICATION

If this form is properly completed and returned to the school nurse, the Walton County School System may assist parents when their child's physician has prescribed medication for the child. The medication will only be given if it is delivered to the nurse or his/her designee in the original bottle marked with the student's name, dosage, time of administration, physician, pharmacy, and the date of expiration.

Student's Name _____ DOB _____ FTE or SS # _____

School _____ Grade _____ Teacher _____

STATEMENT/ ORDER OF PHYSICIAN

Medication _____ Date of Prescription _____

Number or amount of medication received: _____ Dosage to be given _____

Time(s) to be given at school: _____ Discontinue medication on _____

Allergies: _____ Diagnosis: _____

Possible medication side effects: _____

Other medication the student is taking: _____

Print Physicians Name _____

Physicians Signature: _____ Date _____

Physician's Address: _____ Phone: _____

TO BE COMPLETED BY SCHOOL HEALTH CLINIC PERSONNEL ONLY

Date rec'd:	Quantity rec'd:	Staff receiving:
Date returned:	Quantity returned:	Staff returning:

STATEMENT of PARENT/GUARDIAN

As the parent/guardian of the above-named student, I do hereby request the school system give medication to the above-named student at the times listed below. I understand that the school system is not legally obliged to administer medication to the student. School personnel will administer the medication. I agree not to institute suit against the school system for the administration or non-administration of the medication, to defend and hold the school system harmless from any liability resulting from the administration or non-administration of the medication, and to defend and indemnify the school system and its employees from any liability arising out of this agreement. I understand that it is my responsibility to notify the school nurse or designated health personnel immediately concerning any medication changes. As the parent/guardian I also authorize the prescribing physician named above to discuss with the principal or his/her designated staff member any matter regarding the medication to be administered or treatment to be performed. I also authorize the school to monitor the effectiveness of ADD/ADHD medication with the above listed physician via the ADD/ADHD Questionnaire.

Signature of Parent/Guardian _____ Date: _____

Home Phone: _____ Work Phone: _____

SERVICE PLAN for SCHOOL BASED MEDICAID SERVICES

My child is eligible for Medicaid or Peachcare YES ___ NO ___ Number _____

My child is receiving Special Ed. Services YES ___ NO ___ Nursing is in the IEP YES ___ NO ___

I understand that the school system is able to file Medicaid or Peachcare for partial reimbursement for the administering of the above listed 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 understand that I may withdraw permission in writing at anytime by notifying the Special Education Director.

My signature below authorizes the prescribing physician named below to release any information to the Walton County School System or their designee regarding the medication/treatment to be administered. I also understand that my signature authorizes the Walton County School System to release pertinent information to the physician.

Signature of Parent/Guardian _____

Date _____

