SCCPSS

AUTHORIZATION TO GIVE MEDICATION ON FIELD TRIP

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed.

STUDENT'S NAME: _____

TEACHER: _____ GRADE: _____

I request that the Healthcare Professional, through the principal or designee, supervise/assist in the administering of medication to my child, according to the instructions stated 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.
- Parent/guardian must provide specific instructions, as well as the medication and related equipment to the principal or clinic personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes.
- 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 office/clinic by the parent/guardian.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued or at the end of each school term if not picked up by the parent/guardian.

Name of medication: _____

Dose: _____ Route (by mouth, topical, etc.) _____Med Count at sign in: _____

Time(s) to be given: _____ Stop medication on: _____

Condition/Illness Requiring Medication: _____

Allergies: _____

Healthcare Provider's Name_____Phone: _____

I hereby authorize the personnel, employees and officials of the Chatham County School District to assist my child in taking prescription/over-the-counter medication(s). I understand that, in the event of a change in medicine, I am responsible for signing a new request form. I also understand medications not picked up by the end of the school year be discarded. **Asthma and/or Food Allergy Action Plan given.** (circle form)

_____ _____ _____

Parent/Legal Guardian signature Print Name Date

Home Phone: _____ Work Phone: _____ Cell Phone: _____

_____ _____

Received by Date

REVISED 1/16/20

Savannah-Chatham County Public School System

Medication Administration Record

(Use for Prescription and Non-Prescription Medications)

USE BLACK OR BLUE INK ONLY

STUDENT INFORMATION

STUDENT'S NAME:	PRESCRIPTION NO.	
MEDICATION:	AMOUNT:	TIME(S):

LEGEND OF INITIALS / SIGNATURES

INITIALS	SIGNATURE	INITIALS	SIGNATURE	CODE	DESCRIPTION
1.		5		O	No Show
				W	Dosage withheld
2		6		A	Absent
				M	Medication low notification
3		7		F	Field Trip
				E	Early dismissal
4		8		N	No medication available

ADMINISTRATION RECORD

DATE	HOUR	INITIAL	MED. COUNT	DATE	HOUR	INITIAL	MED. COUNT	DATE	HOUR	INITIAL	MED. COUNT

FORM # 100-440-0002