Authorization to Give Medication at School for Student with Multiple Medications

(Use for Prescription and Non-Prescription Medications)

Permission is hereby granted to the local principal or his/ her designee to supervise my child in taking the following prescribed medication.

STUDENT'S NAME_____ ***ALLERGIES***_____

1. **MEDICATION**_____DOSAGE_____AMOUNT _____TIME(S)_____

   START DATE_____END DATE_____MED COUNT AT SIGN IN_____

2. **MEDICATION**_____DOSAGE_____AMOUNT_____TIME(S)_____

   START DATE_____END DATE_____MED COUNT AT SIGN IN_____

3. **MEDICATION**_____DOSAGE_____ AMOUNT_____TIME(S)_____

   START DATE_____END DATE_____MED COUNT AT SIGN IN_____

4. **MEDICATION**_____DOSAGE_____AMOUNT_____TIME(S)_____

   START DATE_____END DATE_____MED COUNT AT SIGN IN_____

I hereby release and discharge the Savannah-Chatham County Public School System, its employees, and officials, from any liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication and I hereby release said aforementioned officials from any liability because of any injury or damage which might occur.

I request that the Healthcare Professional, through the Principal or Designee, supervise/assist in the administering of medication to my Child, according to the instruction stated on this form. 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 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 medication 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, counted and signed in with the Principal/Nurse/Designee.***
- ***Unused medication will be disposed of within one week after the medication is discontinued, or at the end of each school term if not picked up.***

I give the Principal/Nurse/Designee permission to contact my child's health care provider to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

Signature of Parent/Guardian_____Date_____

Work Phone#_____Home Phone#_____Cell Phone#_____

Received by_____Date_____

Asthma, Seizure, and/or Food Allergy and Anaphylaxis Action Plan given to Parent/Guardian. (Circle all that apply)