



MEDICATION AUTHORIZATION FORM

Student's Name _____ D.O.B. _____ Weight _____

School _____ Homeroom Teacher _____ Grade _____

Home Phone _____ Cell Phone _____

Allergies _____

Mother's Name _____ Day Phone _____

Father's Name _____ Day Phone _____

Physician's Name _____ Day Phone _____

Illness (reason for medication) _____

Is this a Recurring Illness? Yes _____ No _____

THE SCHOOL WILL NOT ACCEPT MORE THAN A ONE-MONTH SUPPLY OF PRESCRIPTION OR OVER-THE-COUNTER MEDICATION. THE LEAD NURSE WILL EVALUATE ON AN INDIVIDUAL BASIS THE ADMINISTRATION OF CONTROLLED MEDICATIONS AND/OR MEDICATIONS THAT MAY ALTER VITAL SIGNS OR LEVELS OF CONSCIOUSNESS. IT IS THE EXPECTATION OF CCSD THAT MEDICATION SHOULD BE BROUGHT TO THE SCHOOL BY THE PARENT/GUARDIAN.

Medication _____ Expiration Date _____ Amount _____

Time to be taken _____ AM _____ PM OR as needed _____ every _____ hours

How is the medication to be administered? _____ by mouth _____ eye drop _____ ear drop
_____ topical (on the skin) _____ other

Possible Side Effects _____

AFTER SCHOOL PROGRAM (ASP) REQUIRES A SECONDARY LABELED PHARMACY CONTAINER FOR PRESCRIPTION MEDICATIONS TO BE ADMINISTERED BY ASP STAFF. THE PRIMARY CONTAINER WILL BE KEPT IN THE CLINIC.

PRESCRIPTION MEDICATION MUST BE IN THE ORIGINAL PHARMACY CONTAINER. THE WRITTEN INSTRUCTIONS ON THE CONTAINER FOR DOSAGE AND ADMINISTRATION TIMES WILL BE FOLLOWED. A NEW CONTAINER MUST BE PROVIDED FOR CHANGE IN DOSE OR TIME.

OVER-THE-COUNTER MEDICATIONS MUST BE IN THE ORIGINAL SEALED CONTAINER. DOSAGE WILL NOT EXCEED INSTRUCTIONS ON LABEL REGARDLESS OF PARENT INSTRUCTIONS. OVER-THE-COUNTER MEDICATIONS WILL BE GIVEN FOR ONLY 7 CONSECUTIVE DAYS. A PHYSICIAN'S APPROVAL FORM MUST BE COMPLETED FOR LONGER TREATMENT.

I, _____, authorize the physician's office to release confidential information about my child.

I authorize the personnel of _____ to assist my child in taking medication. I hereby release and waive, and further agree to indemnify, hold harmless or reimburse the Cherokee County Board of Education, the individual members, agents, employees and representatives thereof, from and against, any claim which I, any other parent or guardian, any sibling, the student, or any other person, firm or corporation may have or claim to have, known or unknown directly or indirectly, for any losses, damages or injuries arising out of, during or in connection with the administering of this medication.

Signature of Parent/Guardian _____ Date _____

DO NOT RETURN THIS FORM UNLESS MEDICATION WILL BE TAKEN AT SCHOOL