District Health Services SHS-2 Form

School Year: _____

Authorization for Students to Carry a Prescription Inhaler, Epinephrine, Insulin, or Other Approved Medication*

(JGCD Operating Guideline on Medication Administration and Storage)

Student Name_____ **Grade** _____ **DOB** _____

(PRINT LEGIBLY)

I AGREE TO THE FOLLOWING: ***(ONE MEDICATION PER FORM) – SUBMIT FORM TO THE SCHOOL CLINIC***

- I need to carry the following prescription-labeled inhaler, epinephrine, insulin, and/or approved medication _____.

  (PRINT NAME OF MEDICATION LEGIBLY)
- I have been instructed in the proper use of my labeled medication and fully understand how it is administered. I will keep this medication with me and on my person at all times. I will not allow another student to use my medication and/or medical supplies under any circumstances. I also understand that should another student use my prescription or medication, the privilege of carrying my medication may be reassessed and/or revoked. I also accept the responsibility for notifying the Clinic Assistant or Cluster School Nurse/ Special Education Nurse each time I take my medication. If on a field trip, I will notify the teacher/FCS staff chaperone.

_____ _____

Student Signature **Date**

(District Health Services strongly encourages each student to keep a second prescription inhaler, Epipen, additional Insulin or other prescribed emergency medication in the school clinic in case of emergency and in the event the self-carried medication is lost or left at home.)

To Be Completed by Parent/Guardian

I hereby request that the above named student, over whom I have legal guardianship, be allowed to carry and use this medication at school:

- I accept legal responsibility should the medication be lost, or not immediately available, given, or taken by a person other than the above named student. I understand that if this happens, the privilege of carrying the medication may be reassessed and/or revoked;
- I accept the responsibility to inform the school of all medication changes or new dosages, and will submit a new form to reflect each change;
- Medications must be in their original labeled container;
- I release Fulton County School System (FCS) and its employees of any legal responsibility when supervising or assisting in this medication administration or when the above named student administers his/her own medication (to include choking, allergic reaction, side effects and/or health risks related to this medication);
- Completion of this form authorizes District Health Services to discuss this medication order/request with the prescribing healthcare provider if indicated or needed.
- Pursuant to FCS Medication Administration Policy, Middle School students may carry the following over-the-counter medications with the completion of this form: Acetaminophen, Antacids, Aspirin, Cough or Throat Lozenges, Ibuprofen, Midol or Oral Antihistamines. (High School Students may also carry these approved medications but no form is required). These medications must be kept in the original containers.

_____ _____ _____

Parent/Legal Guardian Signature **Print Name Legibly** **Date**

Home Phone: _____ **Work Phone:** _____ **Cell phone:** _____

Healthcare Provider and Parent/Guardian: ***Please turn form over for additional information and instructions.***

STUDENT NAME:	GRADE:	DOB:

To be completed by the Physician/Healthcare Provider

(For Prescription Medication ONLY – must be labeled and in its original container)

MEDICATION NAME:	PRESCRIBED DOSAGE:
POSSIBLE SIDE EFFECTS:	
ADMINISTRATION, ROUTE AND OTHER SPECIAL INSTRUCTIONS:	
DIAGNOSIS/CONDITION OR ILLNESS REQUIRING MEDICATION:	

_____ _____

Physician Signature **Date**

Physician Name (please PRINT legibly): _____

Office/Contact Number:_____ **Fax:**_____

To Be Completed by Parent/Guardian

Emergency Contact Name and Number:

Name:_____ Home Phone:_____

Work Phone:_____ Cell Phone:_____

***Other Approved Medication – shall be defined as prescribed medication used for emergency purposes and/or medication approved by District Health Services in collaboration with the student's parent/guardian or healthcare provider.**

Fulton County Schools reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate.

This form is effective only for this school year and includes all school sponsored Fulton County Schools System activities and summer school.

_____ _____

Cluster School Nurse/Special Education Nurse Signature **Date Received**

This Section to be completed by Clinic Assistant/Cluster School Nurse/Special Education Nurse ONLY

Date Received:	Medication Name:	# of Doses:
Expiration Date:	Completed by:	Date Returned to Legal Guardian:

If you need this document/information in a different language, please call to (470)254-6827 or send an email to districtlanguageassistance@fultonschools.org

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