Marietta city schools
A Georgia Charter System

Marietta City Schools Assistance with Medication/Procedure

Parent /Guardian Please Complete All Items in this Section

Student's First Name: _____ Student's Last Name: _____
Age: _____ Date of Birth:_____
School:_____Teacher:_____Grade:_____
Parent Name: _____Parent Phone: _____

Parental Authorization

I authorize the personnel of Marietta City School District to assist my child in taking medication. I hereby release and waive, and further agree to indemnify, hold harmless or reimburse Marietta City Schools, 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 administration of this medication/procedure. ☐ **Yes** ☐ **No**

My child receives Medicaid/Peach Care for Kids. ☐ Yes ☐ No Number_____

I understand that the school system can file with Medicaid for partial reimbursement for the administration of this medication/procedure and I do hereby authorize the school system to bill for the services above. If I decide I no longer want the school to bill Medicaid, I understand that I must notify the school in writing. ☐ **Yes** ☐ **No**

The undersigned authorizes the prescribing physician named below to release any information to the School Board or their designee regarding the medication/treatment to be administered. I, the undersigned, authorize the Marietta City Schools to release pertinent information to the physician. ☐ **Yes** ☐ **No**

Signature of parent/guardian_____ Date_____

Parent/Guardian: Complete This Section For OTC Medications Given for Less Than 10 Consecutive Days.
*****Physician Required to Complete and Sign This Section for All Prescription Medications and OTC Medications Given For More Than 10 Consecutive Days.**

Name of Medication/Procedure_____
Diagnosis:_____
Dose: _____ Scheduled: ☐ PRN: ☐
Time : _____Route (oral, injection, etc.)_____
Goal of This Medication/Procedure:_____
This request is valid from (dates): _____to_____
Possible side effects/comments: _____
☐ Vision and Hearing Screening to be included in plan of care
Provider's Name (print):_____ Provider's Signature: _____
Date_____ Provider's Phone: _____
Provider's Address: _____
Provider's NPI Number: _____

****Prescription medication must be in the original container from the pharmacy. Only the instructions for dosage and times for administration written on the container or received from the physician/provider will be followed. All prescription medications require physician/provider signature. All OTC medications given for more than 10 consecutive days will require physician/provider signature. Parents are responsible for personally collecting from school any unused portion of medication within one week after expiration of the medication and/or physician's order. Medication that is not personally collected by the parent/guardian will be destroyed.*