



MEDICATION ADMINISTRATION/PROCEDURE PERMISSION

Student's Homeroom Teacher _____

School Attending _____

Student's Grade Level _____

Student's Last Name _____

Student's First Name _____

Student's Middle Name _____

Student's DOB _____

If medication can be given at home, before or after school hours, please do so. If medication must be given during school hours, this form must be properly completed and returned to the school nurse.

The medication will only be given at school if it is:

- Delivered by the parent/guardian to the school nurse/principal or his/her designee
- In the original/current bottle marked with the student's name, dosage, time of administration, physician, pharmacy and date of purchase.

The parent/guardian is responsible for bringing medication to school. Do NOT transport medication by the student; this is a violation of the county's drug policy and will result in disciplinary action.

Known Allergies (foods, medicines, other substances): _____

Reason Medication Prescribed: _____

Any other medication taken at home: _____

Physician's Name: _____ Phone: _____

Time(s) medication/procedure to be administered, dosage, and start/end dates

Medication/Procedure: _____

Admin/Procedure Time: _____

Dosage: _____

Start Date: _____

End Date: _____

Side Effects to Report: _____

Special Instructions: _____

Medication/Procedure: _____

Admin/Procedure Time: _____

Dosage: _____

Start Date: _____

End Date: _____

Side Effects to Report: _____

Special Instructions: _____

As parent/guardian of the above-named student, I do hereby request the school system give medication to the above-named student. I understand that the school system is not legally obligated to administer medication except to a student whose disabling condition requires the administration of medication in order to benefit from his/her educational program. I understand that school personnel will administer the medication in accordance with the policy and procedures of the school system. The school system does not provide any medication for students. I understand that students are not allowed to have any prescription or non-prescription medication in their possession.

- I hereby release and discharge the Effingham County Board of Education and its employees, 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 official from any liability because of any injury or damage which might occur.
- I give the above-mentioned personnel permission to contact my child's health care provider to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.
- If applicable, I give permission to bill Medicaid for nursing services as needed.
- I give permission to transport my child to the nearest emergency room in the case of a life-threatening emergency or inability to contact parent/guardian.
- I understand that if this medication or dosage is changed or discontinued, the school must be notified. I also consent to the release of medical information by and to my child's physician.

Guardian/
Parent Name: _____

Emergency
Contact Name: _____

Best
Phone: _____

Relationship: _____

Email: _____

Best
Phone: _____

Guardian/Parent Signature: _____

Date: _____

MEDICATION ADMINISTRATION & PROCEDURE LOG

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