ATLANTA PUBLIC SCHOOLS

PLEASE COMPLETE A FORM FOR EACH MEDICATION / MEDICAL PROCEDURE
Reference: APS Policy JGCD - Medication

ATLANTA PUBLIC SCHOOLS
ADMINISTRATION OF MEDICATION / MEDICAL PROCEDURES

Student's Name_____ **Homeroom**_____

Birthdate_____ **Telephone#**_____ **Emergency #**_____

Address_____

Medication / Medical Procedure_____ **Diagnosis**_____

Starting Date of Medication / Medical Procedure _____

Physician's requirements of dosage / method of administration:

_____

_____

(Please indicate if student is responsible for self-administration and should carry medication/medical equipment

Student is capable and recommended to possess, and self-administer this medication / medical procedure:

NO_____ **YES-Supervised**_____ **YES-Unsupervised**_____

Time medication / medical procedure is to be provided daily_____

Precautions, possible side effects, interventions_____

Drug / Food Allergies_____

Termination date for administering the medication / medical procedure_____

Physician's Name_____

Physician's Address_____

Telephone No._____ **Fax No:** _____

Physician's Signature_____ **Date**_____

- *Parent(s) / guardian(s) by signature below acknowledges that the school is providing for the administration of medication / medical procedure as a courtesy to the parent(s) / guardian(s) and agrees to hold the school and school system harmless in its so doing.*
- *Additionally, authorization is granted to obtain pertinent medical and/or copies of records pertaining to my child's medication and for this information to be shared with pertinent staff as needed.*
- *I understand that effective April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA"), disclosure of certain medical information is limited. However, I herein authorize disclosure of pertinent medical information for the provision of services for my child while in attendance in the Atlanta Public Schools District. This authorization expires as of the last day of this school year, including the summer/ extended year session.*
- **Our school nurses are governed by the Georgia Nurse Practice Act and APS Policy JGCD – Medication, and they will only administer medication in accordance with written medical orders signed by a licensed physician, dentist, or podiatrist. APS nurses will not modify any dosage of medicine based solely on a request or recommendation by a parent or guardian. A parent or guardian seeking a dosage modification must provide the nurse with an appropriate medical order.*

Parent(s) / Guardian(s) Signature_____ **Date**_____

Principal Signature: _____ **Date**_____