



## MEDICATION AUTHORIZATION FORM

Student Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Weight \_\_\_\_\_

School \_\_\_\_\_ Homeroom Teacher \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Allergies \_\_\_\_\_ Reason for Medication \_\_\_\_\_

Medication \_\_\_\_\_ Amount to be given \_\_\_\_\_

Time to be given  Daily at \_\_\_\_\_ AM \_\_\_\_\_ PM *OR*  As needed every \_\_\_\_\_ hours

How is medication to be administered?  by mouth  inhaled  eye drop  ear drop

topical  nasal spray  intramuscular injection  subcutaneous injection  other \_\_\_\_\_

Possible Side Effects \_\_\_\_\_

The school will not accept more than a one-month supply of prescription or over-the-counter medication. The Lead Nurse will evaluate the administration of controlled medications and/or medications which may alter vital signs or level of consciousness on an individual basis. **It is the expectation of CCSD that medication should be brought to the school by the parent/guardian.**

**Prescription medications** 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.

Any product that is to be considered a natural remedy, herb, vitamin, dietary supplement, homeopathic medicine, or medication from another country will not be administered without a Physician's Approval for Non-Prescription Medication form.

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

I authorize the nurse or designated school employee to assist my child in taking medication. I hereby release of 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**