

Fulton County Schools  
Student Health Services

**AUTHORIZATION TO GIVE MEDICATION AT SCHOOL**  
**PARENT MUST SUPPLY MEDICATION TO BE STORED AT SCHOOL**

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, on a field trip or during a school chaperoned "before" or "after" school activity, this form must be completed.

STUDENT'S NAME: \_\_\_\_\_

HOMEROOM TEACHER: \_\_\_\_\_ GRADE: \_\_\_\_\_

KNOWN ALLERGIES: \_\_\_\_\_

I hereby request that the Fulton County School System, through the principal or designee, supervise/assist in the administering of medication to my child, according to the instructions contained in the statement below.

I understand that:

- Medications (both prescription and non-prescription) must be in the original labeled container (no baggies foil, etc.).
- Parent/guardian must provide specific instructions, as well as the medication and related equipment to the school clinic.
- It will be the responsibility of the parent/guardian to inform the school of any changes with the medication - new medication or new doses will not be given unless a new form is completed.
- All medication should be taken directly to the office/clinic by the parent and/or student.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.
- School employees will not assume any liability for supervising or assisting in the administration of medication.
- Completion of this form for Prescription Medication authorizes Student Health Services to discuss the medication order/request with the prescribing health care provider if indicated.

**Circle one: Prescription or Non-prescription**

NAME OF MEDICATION AND REASON FOR TAKING: \_\_\_\_\_

DOSAGE AND TIME OF ADMINISTRATION: \_\_\_\_\_

STOP MEDICATION ON: \_\_\_\_\_

I release the school board, the school, and any school employee from any liability for administering this medication.

\_\_\_\_\_  
PARENT/LEGAL GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**TO BE COMPLETED BY HEALTH CARE PROVIDER FOR PRESCRIPTION MEDICATIONS**

*(If prescription medication, have physician/health care provider complete and sign the following portion)*

CONDITION/ILLNESS REQUIRING MEDICATION: \_\_\_\_\_

POSSIBLE SIDE EFFECTS, IF ANY: \_\_\_\_\_

**SIGNATURE OF HEALTH CARE PROVIDER:** \_\_\_\_\_

**PHYSICIAN NAME AND NUMBER (Print)** \_\_\_\_\_

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*To be completed by Clinic Assistant/Cluster Nurse/Special Needs Nurse only:*

Received Date: \_\_\_\_\_ Medication: \_\_\_\_\_ # of doses: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Revised 05/07