Cherokee County School District

MEDICATION AUTHORIZATION FORM

Student's Name_____ D.O.B._____ Weight_____

School_____ Homeroom Teacher_____ Grade_____

Home Phone_____ Cell Phone _____

Allergies_____

Mother's Name_____ Day Phone_____

Father's Name_____ Day Phone_____

Physician's Name_____ Phone_____

Illness (reason for medication) _____

Is this a Recurring Illness? Yes_____ No_____

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 LEVELS OF CONSCIOUSNESS ON AN INDIVIDUAL BASIS. IT IS THE EXPECTATION OF THE CCSD THAT MEDICATION SHOULD BE BROUGHT TO THE SCHOOL BY THE PARENT/GUARDIAN.

Medication_____ Amount_____

Time to be taken_____AM _____PM *OR* as needed _____every_____ hours

How is medication to be administered? _____by mouth _____eye drop _____ear drop
_____ topical (on the skin) _____other

Possible Side Effects _____

BEFORE AND AFTER SCHOOL PROGRAM REQUIRES A SECONDARY LABELED PHARMACY CONTAINER FOR PRESCRIPTION MEDICATIONS TO BE ADMINISTERED BY THE BEFORE / AFTER SCHOOL PROGRAM. THE PRIMARY CONTAINER WILL BE KEPT IN THE CLINIC.

PRESCRIPTION MEDICATION 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.

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

I authorize the personnel _____ 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 loses, 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