MERIWETHER COUNTY SCHOOL SYSTEM

AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

STUDENT’S NAME: _____________________________________________________

SCHOOL: _________________________ YEAR __________________

TEACHER: _______________________ GRADE ____________

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

❖ Medications 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 principal or clinic personnel.
❖ It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed and a newly labeled container is provided.
❖ All medication will be taken directly to the office/clinic by the parent/guardian.
❖ Unused medication will be disposed of unless picked up within one week after medication is discontinued.

Name of Medication: ______________________________________________________

Dose ___________________________ Route (by mouth, topical, etc) ______________________

Time(s) to be given ____________________________ Stop Medication on: ______________

Healthcare Provider’s Name ____________________________ Phone Number ________________

I hereby authorize the personnel, employees and officials of the Meriwether County School System to assist my child in taking prescribed medication according to district policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

_________________________________________________ ____________________________
Parent/Legal Guardian Signature Date

To be completed by healthcare provider for all medications required for a period longer than two weeks.

Condition/Illness Requiring Medication: ____________________________________________

Possible Side Effects, if any: ______________________________________________________

_________________________________________________ ____________________________
Signature of Healthcare Provider Date