Authorization to Give Medication at School
DeKalb County School District
School Year 20___ to 20____

If medication can be given at home or after school hours, please do so. However, if medication must be given during the school hours, this form must be completed.

Student's Name: _____Date of Birth_____

Teacher: _____Grade:_____

I hereby request that the DeKalb County School District, 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 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 for use 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.
- All medication will be taken directly to the office /clinic by the parent.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

To be completed by Physician for Medication Administration at School

Name of Medication: _____

Dosage, Route and Time of Administration: _____

Stop Medication on: _____

Condition/Illness requiring medication: _____

Possible side effects, if any: _____

Physician's Name (print): _____**Physician's phone:** _____

_____ **Date:** _____
Signature of Physician Licensed to Prescribe

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

_____ **Date:** _____
Parent/Legal Guardian Signature

Home Phone:_____**Work Phone:**_____**Pager/Cell Phone**_____