

Muscogee County School District – Department of Health Services

MEDICATION ADMINISTRATION/MEDICAL AUTHORIZATION AND RELEASE

This form must be completed by the parent or guardian and returned to the school principal in order for the Muscogee County School District to assist parents when their child requires medication during school hours. The medication will only be administered if it is delivered to the principal or designated staff member by the parent or guardian. Prescription medication must remain in the original prescription container and be properly labeled by a registered pharmacist as required by law. Nonprescription medication must also remain in the original container properly labeled with the child's name and specific instructions regarding dosage and time of administration.

Name of Student _____ Age _____ Grade _____

Teachers Name _____ Name of School _____

Address of Student _____ Home Telephone Number _____

Name of Father /Guardian _____ Work Telephone Number _____

Name of Mother/Guardian _____ Work Telephone Number _____

Name of person to contact in an emergency if neither parent or guardian is available _____

Relationship to Student _____ Telephone Numbers Home _____ Work _____

Name of Medication to be given _____

Dosage (amount) and specific time(s) medication is to be given _____

Any known allergies to food or drugs? Yes _____ No _____ If yes, please list _____

Name and address of prescribing physician _____

Any known or expected side effects of this medication _____

Please list any other medications that student is presently taking _____

Special instructions _____

STATEMENT OF PARENT OR GUARDIAN

The undersigned hereby releases and agrees to hold harmless and indemnify the Muscogee County School District and any employee of this school district from any liability whatsoever resulting from the administration or nonadministration of the above described medication to our child during school hours in accordance with the above instructions. I will notify the clinic worker, nurse or school if this medication is changed or discontinued. My signature below indicates that I have read this statement and agree to the terms set forth.

I give my permission for the school nurse to contact my child's physician. Yes _____ No _____

Signature of Parent/Guardian _____ Date _____

Signature of Principal _____ Date _____

Signature of School Nurse _____ Date _____