COBB COUNTY SCHOOL DISTRICT

Form JGCD-7

AUTHORIZATION TO CARRY OVER-THE-COUNTER MEDICATION

Complete this form to allow Elementary and Middle School Students to carry certain over-the-counter (OTC) medications. Elementary School students (grades K-5) may carry cough and throat lozenges. Middle School students (grades 6-8) may carry certain (OTC) medications: Tylenol, acetaminophen, Motrin, Advil, ibuprofen, Midol, aspirin, antacid, cough and throat lozenges and oral antihistamines. All prescription medication, cough and cold medication (except lozenges), antihistamines, and (OTC) medication not listed above shall be kept in the clinic. The student and parent/guardian will be responsible for the following:

1. Obtaining, reading and signing this written permission form before the student is allowed to carry the medication.
2. Ensuring the medication is in its original container and legibly labeled with the student's full name.
3. Reminding the student he/she is not permitted to give his/her medication to other students.
4. Ensuring that the School Nurse has a copy of this signed permission form on file in the clinic and the student carries a copy of the signed form with the medication.

Date: _____

Student: _____ Expiration Date: _____

Name of Medication: _____ Dosing: _____

I hereby release and discharge and further agree to indemnify, hold harmless, or reimburse the Cobb County Board of Education, the Cobb County School District, its employees, agents, representatives, and all other officials, from any and all claims, actions, suits, losses, costs, expenses and liability in case of accident or any other mishap because of negligence in administering such medication or because of side effects, illness or any other injury which might occur to my child through administering such medication. And, I hereby release said aforementioned board, district, employees and officials from any liability, suit or claims of whatever nature and kind, which might arise as a result of administering the medication in accord with this request. I accept legal responsibility for my child should the above medication be lost, given or taken by a person other than the above named student. If this should happen, the privilege of carrying medication will be revoked. I further release the Cobb County School District and its employees of any legal responsibility when the above student administers his/her own medication.

_____ _____

Date Signature of Parent/Guardian

I understand how much and when to take the above named medication. I will not allow another student to take my medication under any circumstances. I also understand that should another student take my medication, the privilege of carrying my own medication shall be taken away and I will be subject to the consequences specified in the code of conduct.

_____ _____

Date Signature of Student

I have seen the above labeled medication bottle and have a copy of this permission form.

_____ _____

Date Signature of School Nurse

******Medication must not be expired******