COBB COUNTY SCHOOL DISTRICT

SY: _____

Expiration Date: _____

**Form JGCD-10**

# AUTHORIZATION TO CARRY PRESCRIPTION MEDICATION

_____ needs to carry the following prescription asthma medication, epinephrine auto injector or diabetic medication with him/her. The above-named student has been instructed in the proper use of the medication and fully understands how to administer this medication. (It is preferable that additional asthma medication, epinephrine auto injectors, or diabetic medication be kept in the clinic in case the first is lost or left at home.)

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|---|---|
| Medication | Dosage and Directions |
| Licensed Health Care Provider's Signature & Stamp | Date |

I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that I will be subject to the consequences of the code of conduct should another student use my prescription. I also accept the responsibility for checking in with the School Nurse to keep her informed of use of my medication in case I start having problems.

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| Student's Signature | Date |

**I hereby request that the above-named student, over whom I have legal control, be allowed to carry and use the prescription medication described above, at school. 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 should the above medication be lost, given or taken by a person other than the above-named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the Cobb County School District and its employees of any legal responsibility when the above-named student administers his/her own medication. I further provide a release for the school nurse or other designated school personnel to consult with the physician regarding any questions that may arise with regard to the medication.**

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|---|---|
| Parent/Guardian Signature | Date |

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