

STUDENT'S NAME:

AUTHORIZATION TO GIVE MEDICATION

If medication can be given at home, before or after school hours, please do so. If medication must be given during school hours, this Form must be completed and filed with the School Clinic.

TEACHER:	GRADE:			
I authorize the Cobb County School District to assist my child in taking this medication. I understand that:				
• Medications must be in the original labeled container. Pharmacists may provide two labeled bottles for this purpose. Medications sent in an unlabeled container will not be given. If your child takes daily medication, please send an extra bottle to be used for field trips and After School Program.				
• The parent/guardian must inform the school of any medication changes. New medication or new doses will not be given unless a				
new form is completed.				
 Medications must be brought to the office/clinic by the parent/guardian. Unused medication will be disposed of unless picked up within one week after medication is discontinued. If medication is given 				
throughout the school year, medication will be disposed of according to the medication Rule Section IX.				
• Completion of this form for prescription medication authorizes Cobb County School District Health Services to discuss the				
medication order/request wit	h the prescribing healthcare prov	ider if indicated and/or needed.		
ONE MEDICATION PER FORM – Submit Form To The School Clinic				
Non-Prescription Medication (to be completed by Parent/Legal Guardian				
Medication Name:		Diagnosis/Condition/Illness Requiring Medication:		
Start Date:	Stop Date:	Dosage, Route*, and Time(s) of Ad	ministration:	
Prescription Medication (This Section MUST be completed by a Physician/Healthcare Provider ONLY)				
Medication Name:		Prescribed Dosage:		
Possible Side Effect:		Route*, Time, and Other Special Instructions of Administration:		
Diagnosis/Condition/Illness Rec	quiring Medication:			
Physician's Signature Prin		nt Physician Name Legibly	Date	
Contact Number:		_ Fax:		
Education, the Cobb County Social claims, actions, suits, losses, cos administering such medication administering such medication.	chool District, its employees, agosts, expenses and liability in cast or because of side effects, illness. And, I hereby release said afor	r, hold harmless, or reimburse the Co ents, representatives, and all other o e of accident or any other mishap be ss or any other injury which might of prementioned board, district, employ ght arise as a result of administering	fficials, from any and all cause of negligence in ccur to my child through ees and officials from any	
Parent/Guardian Signature		Date		
Home Phone:	Work Phone:	Cell Phone:		

^{*}Route: The method that medication is administered, such as by mouth, injection, inhaler, rectum, etc.