

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:	
•	-	taking this medication. I understand that:	
sent in an unlabeled containe	er will not be given. If your child	acists may provide two labeled bottles for this purpose. Medicati I takes daily medication, please send an extra bottle to be used fo	
field trips and After School F			
		administration of all medications. on changes. New medication or new doses will not be given unlessed.	
 The parent/guardian must inf new form is completed. 	orm the school of any medicano	on changes. New medication of new doses will not be given unles	ss a
-	t to the office/clinic by the paren	nt/guardian.	
		nin one week after medication is discontinued. If medication is g	iven
•	-	ccording to the medication Rule Section IX.	
		es Cobb County School District Health Services to discuss the	
medication order/request wit	if the prescribing hearthcare prov	vider if indicated and/or needed.	
ONE I	MEDICATION PER FORM	I – Submit Form To The School Clinic	
	Prescription Medication (to be	e completed by Parent/Legal Guardian	
Medication Name:		Diagnosis/Condition/Illness Requiring Medication:	
Start Date:	Stop Date:	Dosage, Route*, and Time(s) of Administration:	
	•		
_	ation (This Section MUST be c	ompleted by a Physician/Healthcare Provider ONLY)	
Medication Name:		Prescribed Dosage:	
Possible Side Effect:		Route*, Time, and Other Special Instructions of Administrati	ion:
Diagnosis/Condition/Illness Rec	juiring Medication:		
Physician's Signature	Pr	rint Physician Name Legibly Date	
Contact Number:		Fax:	
Education, the Cobb County Social claims, actions, suits, losses, cost administering such medication administering such medication.	chool District, its employees, ago tts, expenses and liability in cast or because of side effects, illne And, I hereby release said afo	y, hold harmless, or reimburse the Cobb County Board of gents, representatives, and all other officials, from any and al se of accident or any other mishap because of negligence in ses or any other injury which might occur to my child through orementioned board, district, employees and officials from a light arise as a result of administering the medication in according	h ny
Provide at the	G:4	- Date	
Parent/Guardian Signature		Date	
Home Phone:	Work Phone	Call Phone:	

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