COBB COUNTY SCHOOL DISTRICT

Form JGCD-2

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.

STUDENT'S NAME: _____

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.
- Written permission of the parent/guardian is required for the administration of all medications.
- 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 with the prescribing healthcare provider 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 Administration:

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 Requiring Medication:	

_____ _____ _____

Physician's Signature | Print Physician Name Legibly | Date

Contact Number: _____ Fax: _____

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.

_____ _____

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.