

GREENE COUNTY PUBLIC SCHOOLS

MEDICATION AUTHORIZATION FORM

(This Form must be completed yearly)

Greene County Primary 985.5279 Fax 985.1321
Nathanael Greene Elementary 985.5275 Fax 985.5287
William Monroe Middle 985.5240 Fax 985.1359

Ruckersville Elementary 985.1472 Fax 990.9432
William Monroe High 985.5273 Fax 985.1461

We attempt to discourage administration of medication in the schools. However, if your medical provider decides it is necessary for your child to receive a medication during the school day, the following guidelines must be followed.

- It is recommended that the first doses of medication be administered at home.
- Prescription medication in pill form must be brought to school by an adult. The prescription pills will also need to be counted in the presence of school personnel and a form should be completed by the adult and school personnel.
- Over the counter medication and inhalers used for asthma can be brought to school by the student.
- All medication needs to be in the original bottle or box with the current prescription label on the container. Upon request, most pharmacists will provide you with a duplicate bottle to keep a portion of the prescription at home.
- Both prescription and non-prescription medication must be labeled with the student's name, medication name, amount to be given, and time to be given.
- All medication must be delivered to the office or clinic at the beginning of the school day.
- Medication will only be given in the clinic or school office. Students are not permitted to take any medication in the classroom or at lunch, with the exception of inhalers for asthma and if deemed necessary by medical provider in which case the student must have an **Individualized Health Care Plan**.
- Students who are granted permission to carry and self administer medications must sign a **Contract for Self-Carried/Administer Medication**.

NAME OF STUDENT _____

DATE OF BIRTH _____

MEDICATION NAME _____

REASON FOR TAKING MEDICATION _____

AMOUNT TO BE GIVEN (How many mg?) _____

TIME(S) TO BE GIVEN _____

NUMBER OF DAYS TO BE GIVEN _____

I/We, the parent/guardian, authorize the school to assist our child in taking oral medication. I/We also agree that we will not hold liable any member of the school staff who is directed by us (the parents) and the school administrator to assist our child in taking the above medication.

Signature of parent/guardian

Date

TO BE COMPLETED BY MEDICAL PROVIDER (only for Prescription Medication)

Signature of Medical Provider

Date

Printed name of Medical Provider

Initials NECESSARY to carry at all times. Student has demonstrated the knowledge and ability to self administer this medication properly and safely.

Initials NOT necessary to have with them at all times.

Initials

Revised 02-08