Humphreys County Board of Education

MEDICATION ADMINISTRATION AUTHORIZATION

Medication shall be administered only when the student's health requires that it be given during school hours. It is the parent/guardian's responsibility to **BRING** this medication to school and remove any unused medication when treatment is completed. All medication must be brought to school in the original container.

All prescription medication must have a pharmacy label with the following information:

1. Name of Student
2. Name and dosage of medication
3. Pharmacy name, address and phone
4. Route of administration or other directions
5. Prescription Number
6. Licensed Provider's Name
7. Date Filled

All non-prescription medication must be brought to school in the ORIGINAL manufacturer's labeled container with the ingredients listed.

MEDICAL AUTHORIZATION

_____ ___/___/___ _____ _____/____

Full Name of Student Date of Birth School Teacher Grade

Name of Medication:_____

Form of Medication/Treatment: *(Please Mark the Appropriate Below)*

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ G-Tube ☐ Other_____

Schedule:(Time to Administer) _____☐am ☐pm Dosage:(Amt. to Administer)_____

START MEDICATION: ☐ Date Form Received by School Personnel *(Official Use Only)* Date Received ____/____/____

STOP MEDICATION: ☐ End of School Year ☐ Other Date/Duration: ____/____/____ ☐ For Episodic/Emergency Only!

Special Storage Requirements: ☐ None ☐ Refrigerate ☐ Other:_____

Reason Medication is Needed at School:_____

Restrictions and/or Important Side Effects: ☐ None Anticipated ☐ Yes

If YES, Please Describe:_____

_____ _____ ____/____/____

Printed Name of Provider Signature of Provider Date

AUTHORIZATION BY PARENT/GUARDIAN OF MEDICATION BY SCHOOL PERSONNEL

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by any person employed by the Humphreys County School System, the undersigned parent/guardian hereby agrees to release the Humphreys County School System and its personnel from any legal claim they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student. I will assume full responsibility for any side effects and complications that my child may have as a result of taking this medication.

_____ _____ ___/___/___

Parent/Guardian Signature Work/Home/Cell Phone Date