311 South East Street
Kingsland, GA 31548

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Authorization to Give Medication at School

Student's Name: _____ Birth Date: _____

School: _____ Grade: _____ Teacher/Advisor: _____

List any drug allergies/reactions: _____

PARENT OR LEGAL GUARDIAN AUTHORIZATION *(for All Medications)*

Parents/guardians are encouraged to give medications at home whenever possible. If it is necessary for a student to take medication at school, the following procedures should be followed:

• The parent/guardian or student (age appropriate) must transport prescription medicines to the health clinic or main office of the school.
• Prescription medications must be in the original prescription bottle, clearly labeled with the student's name, physician's name and contact information, medication name and strength, amount given per dose, route and time of administration, dispensing pharmacy. Over-the-counter medications must be in the unopened original container. The school staff will have the right to refuse to give medication that is questionable or expired. **Narcotic and/or other prescription pain medications (e.g. Tylenol with codeine, hydrocodone, etc) will not be administered at school.**
• Any student possessing prescription or over-the-counter medication not in accordance with these guidelines will be considered in violation of the School District's Code of Conduct and shall be subject to the discipline set forth in the code of conduct and/or the student handbook.
• The parent/guardian must complete an *Authorization to Give Medication at School* form in order for school staff to administer medication.
• The parent/guardian is responsible for notifying the school of any changes in the administration of medications.
• If these procedures are not followed, medication may not be dispensed at school.
• Unused medication will be disposed of unless picked up within one week after the medication is discontinued and/or at the end of the school year.
• I understand my child will not be forced to take medications.

Name of medication: _____ ☐ Daily OR ☐ Give As Needed

Dosage: _____ Frequency/Times to be given: _____

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any: _____

Medication for: ☐ This School Year _____ ☐ Following Dates Only _____

Physician's Name: _____ Phone Number: _____

I, this child's parent/guardian, hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's medication and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Camden County Schools. This authorization expires as of the last day of the school year.

_____ _____
Parent/Legal Guardian Signature ***Date***

_____ _____ _____
Home Phone ***Work Phone*** ***Cell / Pager***

EMERGENCY TREATMENT AUTHORIZATION

Child's name_____Date_____

Parent's name _____Phone (home) _____

Address _____Phone (work) _____

Physician's name _____

Physician's address/phone_____

In case of an allergic reaction or medicine error, appropriate action(s) will be taken.

The school may contact my child's physician in case of emergency or to clarify any questions about the medication(s) my child is taking at school.

In the event that a parent or emergency contact cannot be reached and the situation is serious, the school has my permission to contact 911 for emergency transport to the closest hospital for treatment. Fees for transportation and medical services will be the responsibility of the parent/guardian signed below.

Signature of Parent/Guardian _____

Health Insurance _____Policy Number_____

Medicaid/Peach Care (circle one) Policy Number _____