IRWIN COUNTY MIDDLE/HIGH SCHOOL

149 Chieftain Circle
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AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

If medication can be given at home, before or after school hours, please do so. However, if medication is prescribed by the physician to be given during school hours, this form must be completed. Please write one medication per page.

Student's Name: _____

Teacher: _____ Grade: _____

I request that ICMS/ICHS (through the school nurse, principal or designee) supervise/assist in the administering of medication to my child, according to the instructions below. I understand that:

- Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacists can provide a duplicate labeled container with only the school doses.
- Parent/guardian must provide specific instructions, as well as the medication and related equipment to the principal or clinic personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- All medication will be taken directly to the office/clinic by the parent.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

Name of Medication: _____

Dose: _____ Route (oral, topical, etc): _____

Time(s) to be given: _____ Stop Medication on (date): _____

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any: _____

Physician's Name: _____ Physician's Phone: _____

I hereby authorize the personnel, employees and officials of the Irwin County School District to assist my child in taking prescribed medication according to district policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

_____ _____

Parent/ Legal Guardian signature **Date**

Home Phone: _____ Work Phone: _____ Cell Phone: _____

To be completed by School Health Clinic Personnel only:

_____

Date received: Name of Medication: Number of Doses: