

Georgia School for the Deaf
Authorization to Give Medication at School

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed. Please write one medication per page or use the attached page for multiple medications.

Student's Name: _____

Teacher: _____ Grade: _____

I request that Georgia School for the Deaf, through the superintendent 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/legal guardian must provide specific instructions, as well as the medication and related equipment, to the superintendent or clinic personnel.
- It will be the responsibility of the parent/legal 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 (by mouth, topical, etc.): _____

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

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any: _____

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

To be completed by School Health Clinic Personnel only:

Date received: _____ Name of Medication: _____ # Doses: _____

I hereby authorize the personnel, employees and officials of Georgia School for the Deaf, State School, 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: _____