Chattooga County Schools
Medical Authorization Form

Student's Name:_____ School: _____ DOB ____

Home Room Teacher: _____ Grade Level: _____

The principal or his/her designee will dispense medicine to students according to the following guidelines:

- The parent/guardian should complete and sign the Medication Authorization Form. Medicine cannot be given without written permission and instructions for the parent/guardian.
- The parent/guardian should bring medicine and related equipment to the principal or his/her designee. Please do not send medicine to the school by way of the student.
- **NO MEDICATION CAN BE TRANSPORTED ON THE BUS!**
- Most all medications will be kept in the school office with the exception of life saving medications such as rescue inhalers and Epi Pens that may be kept with the student according to individual severity (in an emergency seconds count).
- Prescription medicine must be in the original labeled container. The label must include the student's name, the name of the medicine, instructions for dispensing the medicine, and the doctor's name. Pharmacists can provide a duplicate labeled container with only the dosage to be given at school.
- Over-the-counter medicine must be in the original container and marked with the student's name.
- A new Medication Authorization Form must be completed whenever a new medicine or dosage is to be given to the student.
- At no time can the school accept out of date medications, if your student's medication has expired it is your responsibility to supply a new prescription. The school will notify you if your stock of medication has expired. All medications should be picked up at the end of the school year; any medications not picked up at the end of the school year will be discarded.

I also understand that in the event of an emergency and I cannot be reached the school will have my child transported to the hospital via EMS/911 services to receive appropriate treatment.

Parent Signature: _____ Date: _____

PLEASE COMPLETE BACK OF THIS FORM:

Child's Physician: _____ **Phone:**_____

Health History_____

Allergies? __YES NO (medicine, food, stings or etc.) ***If yes please explain***

_____

What happens when allergic reaction occurs?_____

_____

Does student have an Epi-Pen? YES NO *At school? YES __NO

Does student have Asthma? __YES __NO *Type of Asthma: MILD MODERATE SEVERE (circle one)

Does student have Inhaler at school? __YES __NO *Date of last episode? _____

List all medications student is currently taking:

At Home: _____

At School: _____Dosage_____Time_____

What type of medical coverage does your child have? __Medicaid __Private __Peachcare

__None Does your child have dental insurance? __YES __NO

Does your child wear eye glasses or contacts? __YES __NO

My child my receive hearing and vision screening at school. __Yes __NO

My Child can receive over the counter medications? __Yes __NO

Please circle medications your child <u>CANNOT TAKE.</u> (No over the counter cold meds will be given)

Acetaminophen (Tylenol)	Antifungal Cream	Ibuprofen (Advil)	Antacid (Maalox, Rolaids, Tums)
Calamine	Antibiotic Ointment	Throat Lozenge	Hydrocortisone Cream
Benadryl Liquid	Benadryl Cream	Orajel	Cough Drops

Child's Name _____

Parent Signature _____ **Date** _____