## **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 by a parent or guardian.

Studen	t's Name: _		DOB:		
Teache	r:	· · · · · · · · · · · · · · · · · · ·			
•	Medications Medications container w Parent/guar personnel. It will be the given unless All medicati	e instructions in the statements below. It is must be in the original labeled contain ith only the school doses, if needed. It is must provide specific instructions, a responsibility of the parent/guardian to a new form is completed, and a newly lon will be taken directly to the office/clidications will be disposed of unless picked.	er (no baggies, foil, etc.). Pharmacists can as well as the medication and related equi inform the school of any changes. New mabeled container is provided.	provide a duplicate labeled  pment to the principal or clinic  edication or new doses will <u>not</u> be	
Dose: _		Route: (O	ral, topical, inhalation, etc.):Stop Dat		
Healtho	are Provide	r:	Phone:		
medicati	ion. I understa	and that in the event of a change in med	ne Cartersville City School District to assist icine, I am responsible for presenting a new old Nurse any matter regarding the medicat	w authorization form. <u>I authorize</u>	
Parent/Legal Guardian Signature			Date		
ate	Quantity Received	Received From (Print)	Signature	Signature of Staff Member Counting	

Date	Quantity Received	Received From (Print)	Signature	Signature of Staff Member Counting
<del></del>				