SB-157a
(5-16)

GILES COUNTY PUBLIC SCHOOLS

Parental/Physician Consent for Administering Prescription Medication
(Use a separate authorization for each medication)

Student Name_____ Birthdate_____

Allergies_____ Grade_____

Parental Consent

I am the parent/guardian of _____. I give my permission for him/her to take the following prescribed medication while in school. I hereby acknowledge that I have read and understood School Board Policy JHCD - on Administering Medicines to Students. I hereby release Giles County Public Schools and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the prescriber listed below.

This medication has been administered at least once prior to requesting administration at school.

_____ _____ _____
Parent/Guardian Signature Daytime Phone Date

MEDICATION AUTHORIZATION
(for use by Physician/Licensed Prescriber ONLY)

Relevant Diagnosis_____ Name of Medication_____

Dates medication must be administered at school: (check one)
_____ Short Term _____ Episodic/Emergency Events Only
_____ Every Day at School _____ PRN

DOSAGE (Amount)_____ Route_____ Form_____ Times(s) of day_____

A.) Can serious reactions occur if the medication is not given as prescribed? YES_____ NO_____
If yes, describe:
B.) Serious reactions/adverse side effects from this medication may occur? YES_____ NO_____
If yes, describe:

ACTION/TREATMENT for reactions:_____
Report to you? YES_____ NO_____

Special Handling Instruction: Refrigeration_____ Keep out of Sunlight _____ Other_____

Asthmatic/Diabetic/Epi-pen ONLY: This student is responsible for self-administering this medication?
YES (**supervised**)_____ YES (**unsupervised**)_____ NO_____

This student may carry this medication **at school**? YES____ NO____ **on the Bus** YES____ NO____

Physician's Name (PRINT)_____ Phone #_____

Physician (SIGNATURE)_____ Date_____

Medicine must be in the original container and delivered to the principal, school nurse, or school division designee by the parent/guardian of the student. Medication not picked up by the parent/guardian by the end of the school year, will be discarded. Each 'Medication Authorization' must be renewed at the beginning of each school year.