THOMASVILLE CITY SCHOOLS
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.

Student's Name: ____

Teacher: ______________________________________ Grade: __________

I request that the Thomasville City Schools, through the nurse or designee, supervise/assist in the administering of medication to my child, according to instructions in the statements 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. The school is not responsible for any medication brought or lost by student until the point it is turned over to school staff.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued or school year has ended.

Name of Medication: ____

Dose: ______________________________ Route (by mouth, topical, etc.): __________

Time to be given: ______________________________ Stop medication on: ______________

Condition/Illness Requiring Medication: ______________________________________

Possible Side Effects, if any: ____

Physician's Name: ____

Insurance: BCBS____ Medicaid____ PeachCare____ State Merit____ Other______

I hereby authorize the personnel, employees and officials of the Thomasville School System to assist my child in taking prescribed medication according to district policy. I release the school board, the school, and any school employee from any liability or adverse reactions that may occur as a result of taking this medication.

______________________________ ______________________________

Parent/Legal Guardian Signature Date

Home Phone______________ Work Phone______________ Cell Phone______________