Barrow County School System Medication Authorization

Student's Name____**Birth Date**___________________________

School____**School Year**____________________________

Grade______________________________**Teacher**____

Please note the following:

1. All medications whether *prescription* or *over-the-counter* must be in the **original labeled container** (no baggies or foil).
2. A parental note **cannot** override the labeled directions for prescription or over-the-counter medication.
3. Parental / guardian must provide specific instructions, as well as the medication and related equipment to the principal or clinic personnel.
4. It is the responsibility of the parent / guardian to inform the school of any changes. If there is a change in prescription doses either a new labeled container or a signed note from the prescribing physician must be provided.
5. All medication will be taken directly to the office / clinic.
6. Unused medication will be disposed of unless picked up within one week after medication is discontinued.
7. The school will contact the prescribing physician or dispensing pharmacy as needed in regards to prescribed medicines.
8. It is the responsibility of the parent / guardian to ensure that all of the medication in the container arrives to school.

Name of Prescription Medication____

Dosage and Time of Administration____

(Note if different from labeled directions the school will not give the medications)

Number of Pills in Container_________________________**Stop medication on**______________________________

Reason for Medication____

Physician's name____

Address and Phone____

Name of Over-the-counter medication____

Dosage and Time of Administration____

(Note if different from labeled directions the school will not give the medications)

Number of Pills in Container_________________________**Stop medication on**______________________________

Reason for Medication____

I hereby request that the Barrow County School System, through the principal or designee, supervise / assist in the administration of medication to my child, named above, and according to the instructions contained in the statements above. I release the school board, the school, and any school employee from any liability for administering this medication. This permission must be renewed annually for medications that are needed on a continuous basis.

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Parent / Guardian Signature   Date

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Parent / guardian home, work, cell and pager numbers

BCSN Form 2001-13a