EFFINGHAM COUNTY SCHOOL DISTRICT

MEDICATION ADMINISTRATION PERMISSION

If medication can be given at home, before or after school hours, please do so. If medication must be given during school hours, this form must be properly completed and returned to the school nurse.

The medication will only be given at school if it is:

- Delivered by the parent/guardian to the school nurse/principal or his/her designee
- In the original/current bottle marked with the student's name, dosage, time of administration, physician, pharmacy and date of purchase.

The parent/guardian is responsible for bringing medication to school. Do NOT transport medication by the student; this is a violation of the county's drug policy and will result in disciplinary action.

Student Name:_____ Date of Birth: _____

School attending: _____ Homeroom Teacher: _____ Grade: _____

Known Allergies (foods, medicines, other substances) : _____

Reason Medication prescribed: _____

Physician's Name: _____ Phone: _____

Time/s medication is to be administered, dosage, and Rx # for each medication:

1. Medication: _____ Time/s:_____ Dosage: _____ Rx#:_____
2. Medication: _____ Time/s:_____ Dosage: _____ Rx#:_____
3. Medication: _____ Time/s:_____ Dosage: _____ Rx#:_____

Date administration should begin: _____ Discontinue medication on: _____

Side Effects which should be reported to parent/physician: _____

Special instructions for storage/administration of drug: _____

Any other medications taken at home: _____

As parent/guardian of the above named student, I do hereby request the school system give medication to the above named student. I understand that the school system is not legally obligated to administer medication except to a student whose disabling condition requires the administration of medication in order to benefit from his/her educational program. I understand that school personnel will administer the medication in accord with the policy and procedures of the school system. The school system does not provide any medication for students. I understand that students are not allowed to have any prescription or non-prescription medication in their possession.

- I hereby release and discharge the Effingham County Board of Education and its employees and officials, from any liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication and I hereby release said aforementioned official from any liability because of any injury or damage which might occur.
- I give the above-mentioned personnel permission to contact my child's health care provider to acquire medical information concerning my child's diagnosis, medication, and other treatment (s) required.
- If applicable, I give permission to bill Medicaid for the frequencies of services defined on my child's IEP.
- I give permission to transport my child to the nearest emergency room in the case of life threatening emergency or inability to contact parent/guardian.
- I understand that if this medication or dosage is changed or discontinued, the school must be notified. I also consent to the release of medical information by and to my child's physician.

Parent Name: _____ Home Phone: _____ Work Phone: _____

Mobile Phone: _____ E-mail address: _____

Emergency contact Name: _____ Relationship: _____ Phone Number: _____

_____ _____

Signature of Parent/Guardian Date

Revised October 2020

EFFINGHAM COUNTY SCHOOL DISTRICT

MEDICATION LOG

Medication Received					
Medication	**Date Received**	**Brought in by**	**Received by**	**Qty**	**Signature/Initial**

Date	LTC	Initials	Date	LTC	Initials	Date	LTC	Initials

Goals: _____

_____

Returned: _____
Date Amount

Parent: _____
Signature Date

Destroyed: _____
Date Amount

School Nurse: _____
Signature

Witness : _____
Signature

Revised October 2020