

District Health Services SHS-1 Form AUTHORIZATION TO GIVE MEDICATION AT SCHOOL PARENT MUST SUPPLY MEDICATION TO BE STORED AT SCHOOL

This form must be completed if medication has to be administered during school hours, on field trips or during a school chaperoned "before" or "after" school activity. Please give all medications at home before or after school hours when possible as some medication may not need to be given during school hours.

Student Name:		DOB:	School Year:	
		de: Known Allergies		
according to the instructions corfollowing:	ntained in the statement below a	cipal or designee, to supervise/ass nd in accordance with Fulton Coun	ty Schools Medication Poli	cy. I understand the
below.		e in the <u>original labeled</u> container (no b		
related equipment. • The parent/legal guardia	n is responsible for informing the sc	nool receives specific instructions regar hool of any changes with the medication		•
	taken directly to the school office/cl			
Medications that have be	een discontinued must be picked up	sed of at the end of the school year if r within one week or will be properly dis	sposed of by the clinic.	•
administration of medica	tion (to include choking, allergic rea	However, school employees will not a ctions, side effects and/or any health ri norizes District Health Services to di	isks related to this medication).
	provider if indicated and/or need		iscuss the medication order	mequest with the
		ton County School System e		
prescription medications.	i areni/Legar Guardian	authorization signature is	necueu ioi botti pre	socription and non-
 Parent/Legal Guardia	an Signature	Print Name Legib		Date
Home Phone:	Work Phone	9:	Cell Phone:	
C	ONE MEDICATION PER FOR	M - SUBMIT FORM TO THE	SCHOOL CLINIC	
N	ON-PRESCRIPTION MEDIC	CATION (to be completed by	Parent/Legal Guard	ian)
Medication Name:		Diagnosis/Condition/Illness Requiring Medication:		
Start Date: Stop Date:		Dosage, Route and Time(s) of Administration:		
PRESCRIPTION MEDICATION	ION - (This Section MUST	be completed by a Physici	ian/Healthcare Provid	der ONLY)
Medication Name:		Prescribed Dosage:		
Possible Side Effects:		Route, Time and Other Special Instructions of Administration:		
Diagnosis/Condition/Illness (Requiring Medication:			
Physician's Signature		PRINT PHYSICIAN NAME	PRINT PHYSICIAN NAME LEGIBLY DATE	
Office/Contact Numl	ber:	Fax:		
	e completed by Clinic As	sistant/Cluster School Nurs	se/Special Education	Nurse ONLY
Date Received:	Medication Name:		# of Doses:	
Expiration Date:	Completed by:		Date Returned t Legal Guardian:	0
			Leyar Duaruidii:	Revised May 2022