

**DO NOT RETURN THIS FORM UNLESS MEDICATION WILL BE TAKEN AT SCHOOL.**

**CHEROKEE COUNTY SCHOOL DISTRICT  
MEDICATION AUTHORIZATION FORM**

Student's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Weight \_\_\_\_\_

School \_\_\_\_\_ Homeroom Teacher \_\_\_\_\_ Grade \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Allergies** \_\_\_\_\_

Mother's Name \_\_\_\_\_ Day Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Day Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Illness (reason for medication) \_\_\_\_\_

Is this a Recurring Illness? Yes \_\_\_\_\_ No \_\_\_\_\_

**THE SCHOOL WILL NOT ACCEPT MORE THAN A ONE MONTH SUPPLY OF PRESCRIPTION OR OVER-THE-COUNTER MEDICATION. THE ADMINISTRATION OF CONTROLLED MEDICATIONS AND/OR MEDICATIONS WHICH MAY ALTER VITAL SIGNS OR LEVELS OF CONSCIOUSNESS WILL BE EVALUATED ON AN INDIVIDUAL BASIS BY THE LEAD NURSE. IT IS THE EXPECTATION OF THE CCSD THAT MEDICATION SHOULD BE BROUGHT TO THE SCHOOL BY THE PARENT/GUARDIAN.**

Medication \_\_\_\_\_ Amount \_\_\_\_\_

Time to be taken \_\_\_\_\_ AM \_\_\_\_\_ PM **OR** as needed \_\_\_\_\_ every \_\_\_\_\_ hours

How is medication to be administered? \_\_\_\_\_ by mouth \_\_\_\_\_ eye drop \_\_\_\_\_ ear drop  
\_\_\_\_\_ topical (on the skin) \_\_\_\_\_ other

Possible Side Effects \_\_\_\_\_

**BEFORE AND AFTER SCHOOL PROGRAM** REQUIRES A SECONDARY LABELED PHARMACY CONTAINER FOR PRESCRIPTION MEDICATIONS TO BE ADMINISTERED BY THE BEFORE / AFTER SCHOOL PROGRAM. THE PRIMARY CONTAINER WILL BE KEPT IN THE CLINIC.

**PRESCRIPTION MEDICATION** MUST BE IN THE ORIGINAL PHARMACY CONTAINER. THE WRITTEN INSTRUCTIONS ON THE CONTAINER FOR DOSAGE AND ADMINISTRATION TIMES WILL BE FOLLOWED. A NEW CONTAINER MUST BE PROVIDED FOR CHANGE IN DOSE OR TIME.

**OVER-THE-COUNTER MEDICATIONS** MUST BE IN THE ORIGINAL SEALED CONTAINER. DOSAGE WILL NOT EXCEED INSTRUCTIONS ON LABEL REGARDLESS OF PARENT INSTRUCTIONS. OVER-THE-COUNTER MEDICATIONS WILL BE GIVEN FOR ONLY 7 CONSECUTIVE DAYS. A PHYSICIAN'S APPROVAL FORM MUST BE COMPLETED FOR LONGER TREATMENT.

I, \_\_\_\_\_, **authorize the physician's office to release confidential information about my child.**

I authorize the personnel of \_\_\_\_\_ to assist my child in taking medication. I hereby release and waive, and further agree to indemnify, hold harmless or reimburse the Cherokee County Board of Education, the individual members, agents, employees and representatives thereof, from and against, any claim which I, any other parent or guardian, any sibling, the student, or any other person, firm or corporation may have or claim to have, known or unknown directly or indirectly, for any losses, damages or injuries arising out of, during or in connection with the administering of this medication.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

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