CATOOSA COUNTY PUBLIC SCHOOLS
MEDICAL AUTHORIZATION AND RELEASE

Name of Student _____ **Age** _____

Address _____ **Grade** _____

Home Telephone _____ **Teacher** _____

Father's Name _____ **Work #**_____ **Cell #** _____

Mother's Name _____ **Work #**_____ **Cell #** _____

If both parents are unavailable, name of person to contact:

_____

Name **Relationship** **Telephone #**

★ **MEDICATION MUST BE IN THE ORIGINAL PHARMACY CONTAINER WITH INSTRUCTIONS FROM THE PHYSICIAN!** ★

Please indicate those medications that will need to be taken at school.

Medication Name	**Purpose of Medication**	**Dosage (Amount)**	**Schedule (When to Use)**

SPECIAL INSTRUCTIONS (Ex: For what specific symptoms should we give the medication?):

_____

_____

_____

The undersigned hereby releases and agrees to hold harmless and indemnify the Catoosa County Board of Education and any employee of the Board from any liability whatsoever occasioned by the administration or non-administration of the above described medication to our child during school hours in accordance with the above instructions.

The undersigned authorizes the prescribing physician, _____, to discuss with the principal
(Name of Prescribing Doctor)
and his / her designated staff member any matter regarding the medical conditions and medication administered.

The undersigned also authorizes the school to seek emergency medical treatment for child when necessary and appropriate.

_____ _____

Custodial Parent / Guardian Signature **Date**

Revised 5/2010