ASSISTANCE WITH MEDICATION

Date: 05/22/2014

Douglas County School System
Box 1077
Douglasville, Georgia 30133
(770) 651-2000

ASSISTANCE WITH MEDICATION

School_____

Child's Name_____ Date of Birth_____

Address_____ Home Phone_____

Mother's Name_____ Day Phone_____

Father's Name_____ Day Phone_____

Physician's Name_____ Phone_____

Emergency Contact_____ Phone_____

All medication must be placed in an original container. Prescription medications must have the prescription label. Check with your pharmacist if you need a duplicate bottle. Medication not claimed at the end of the school year will be discarded.

Name of Medication_____

Time to be given_____

Dosage_____

Side effects_____

Date to stop giving medication at school: _____

I hereby authorize the personnel of the Douglas County School District to assist my child in taking medication. I understand that in the event of a change in medication, the parent/guardian is responsible for completing a new request form.

In signing this form, I authorize exchange of information/communication between the prescribing physician and Douglas County School System Health Services Coordinators regarding any prescription medication.

_____ _____

Parent/Guardian Signature Date

_____ _____

Physician's Signature (if possible to obtain) Date