Fayette County School Health Services

SCHOOL MEDICATION AUTHORIZATION

Please bring or mail this School Medication Authorization to the school or send to the secure FAX at 770-460-3928.

Student's Name: _____ Birth Date: _____

School: _____ Grade: _____ Homeroom Teacher: _____

List any drug allergies/reactions: _____

PARENT OR LEGAL GUARDIAN AUTHORIZATION

(Required for ALL Medications)

If medications must be given during school hours, this form must be completed. The parent/guardian must provide the school with the over-the-counter or prescription or homeopathic/supplement medication in the original container with unexpired date and will be given as directed on the package or as directed by the below physician. It is the responsibility of the parent/guardian to notify the school of medication changes and complete a new Authorization.

Name of Medication: _____ □ Daily OR □ As Needed

Dosage: _____ Frequency/Times to be Given: _____ Medication Expiration Date: _____

Medication for: □ This School Year 20___ - 20___ □ Following Dates Only _____

Physician's Name: _____ Phone Number: _____

I, this child's parent/guardian, hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's medication and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Fayette County Schools. This authorization expires as of the last day of the school year.

_____ _____ _____ _____

►Parent/Legal Guardian Signature◄ Date Home Phone Work Phone

PHYSICIAN AUTHORIZATION

(Required for Prescription or Homeopathic OR Supplement Medications ONLY)

Name of Medication: _____

Dosage: _____ Route: _____ Frequency/Time to be Given: _____

Start Medication On: _____ Stop Medication On: _____

Condition/Illness Requiring Medication: _____

Common Side Effects of the Medication: _____

Student may carry and self-administer medication due to a life threatening condition: □ Yes □ No

Special Instructions: _____

►Physician's Signature◄ _____ Date: _____

PRINT Physician's Name: _____ Telephone Number: _____

Implemented: June 18, 2001
Revised: August 2003; August 2, 2004; February 20, 2006; March 11, 2008; May 17, 2011; May 13, 2013