AUTHORIZATION TO GIVE MEDICATION

Student Name_____ Date of Birth _____ Grade _____

Parent/Guardian Name _____ Daytime Phone #_____

Please note: ***If medication can be given at home, before or after school hours, please do so.*** If medication must be given during school hours, this form must be completed and filed with the School Clinic. This form must be filled out each school year and revised any time there is a change to the medication instructions. Forms and medications do not carry over to the next school year.

I authorize the Paulding County School District (PCSD) to assist my child in taking the medication listed below. I understand that:

- **All medications must be brought to the clinic/office by a parent/guardian.**
- **Prescription medications** must be in the original container with a label from the Pharmacy. The label must include the student's name, the name of the drug, and instructions for use. It must also include the physician's name and expiration date. We will follow the written instructions on the bottle for dispensing the medication and will require a written note from the Doctor to change this order. All prescription medications will be verified and counted while the parent is present upon medication drop-off.
    - *Completion of this form authorizes PCSD to discuss the prescribed medication order/request with the prescribing healthcare provider if indicated and/or needed.*
- **Over-the-counter medications** must be in the original packaging. The dosage dispensed will follow package recommendations, or a doctor's note will be required to give the medication differently. Over-the-counter medications will only be given for five (5) consecutive days. A note from a physician will be required for longer treatment.
- **It is your responsibility** to pick up all medications and/or medical supplies before the last day of school, or they will be disposed of.

Name of Medications: ** Please note any side effects.
**** Route is how it is to be given (Oral, Topical, Injection, etc.)**

1._____Dosage/Route_____Time_____ Purpose_____

2._____Dosage/Route_____Time_____ Purpose_____

3._____Dosage/Route_____Time_____ Purpose_____

4._____Dosage/Route_____Time_____ Purpose_____

This request is valid from Dates_____ to_____

I authorize the personnel of Paulding County School District to assist my child in taking medication. I hereby release and waive, and further agree to indemnify, hold harmless or reimburse the Paulding 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_____

*** This form will not be accepted without the corresponding medication(s). ***

Revised 5/19/2025