

DEKALB COUNTY SCHOOLS
STUDENT HEALTH SERVICES
**PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION
IN SCHOOL BUILDING DURING SCHOOL HOURS**
Must be Completed Annually

1. To keep this child in optimal health and to help maintain school performance, it is necessary that medication be given during school hours.
2. Nurses and other designated school personnel can assist with self-administration of medication during school hours.
3. In order for medication to be self administered at school, this form must be completed by licensed physician and at least one guardian/parent and be returned to school.

School: _____

Name of child: _____ DOB _____

Diagnosis: _____ Infectious _____ Noninfectious _____
(Please check one)

Allergies: _____

Name of medication: _____ Color, if applicable _____
(Include trade name)

Route of Administration: _____

Form of medication to be given (specify below):

_____ tablet _____ pill _____ capsule _____ liquid _____ inhalation _____ injection** _____ other
** No injection will be given except in extreme emergency, such as allergy to wasp or bee sting or the like.

Dosage (amount to be given): _____ Frequency: _____

Side Effects: _____

Physician's Signature _____ (date) _____ Physician's Name (print or type) _____

Physician's Office Phone/Fax# _____ / _____

***This is your permission to give medication to my child named above as requested by the physician.**

Parent's Signature _____ (date) _____ Home Phone# _____ Work Phone# _____

Pager/Cell# _____ Email address _____

***MEDICATION MUST BE DELIVERED TO SCHOOL BY A RESPONSIBLE ADULT IN THE CONTAINER IN WHICH IT WAS DISPENSED BY THE PRESCRIBING PHYSICIAN, LICENSED PHARMACIST OR PHARMACY.**

Any unused and or expired portions of any medications that are not collected by the parent/guardian within one week will be destroyed.

Revised 3/22/11