Muscogee County School District
Department of Health Services

Medication Administration/Medical Authorization and Release

This form must be completed by the parent/guardian and returned to the school principal in order for the Muscogee County School District to assist parents when their child requires medication during school hours. The medication will only be administered if it is delivered to the principal or designated staff member by the parent or guardian. Prescription medication must remain in the original prescription container and be properly labeled with the child's name and specific instructions regarding dosage and time of administration.

Student_____________________________________ Age___ Grade___

Teacher's Name ________________________ School____

Address of Student_____________________________ Home number________________________

Name of Father/Guardian______________________________ Wk number_____________________

Name of Mother/Guardian_____________________________ Wk Number_____________________

Name of person to contact in an emergency if neither parent/guardian is available_________________

__________________________________ Relationship to Student_____________________________

Home Number__________________ Cell Number________________ Wk Number______________

Name of medication to be given____

Dosage (amount) and specific time(s) medication to be given__________________________________

Any known allergies to food or drugs? Yes___ No___ If yes, please list_________________________

Name and address of prescribing physician____

Any known or expected side effects from this medication_____________________________________

Please list other medications that the student presently taking_________________________________

Special Instruction____

STATEMENT OF PARENT OR GUARDIAN

The undersigned hereby releases and agrees to hold harmless and indemnify the Muscogee County School District and any employee of this school district from any liability whatsoever resulting from administration or non-administration of the above described medication to our child during school hours in accordance with the above instructions. I will notify the clinic worker, school nurse or school if this medication is changed or discontinued. My signature below indicates that I have read this statement and agree to the terms set forth.

I give my permission for the school nurse/ school representative to contact my child's physician Yes___ No___

Signature of Parent/Guardian____ Date_______________

Reviewed by Registered School Nurse____ Date _______________

Revised 5/14