STEWART COUNTY SCHOOL SYSTEM
MEDICATION AUTHORIZATION FORM

(Total completion of this form is mandatory.)

Student: _____ D.O.B._____

School: _____ Grade: _____ Teacher: _____

The medication policy of the Stewart County School System states: medications shall be administered only when the student's health requires that they be given during school hours. Medication must be brought to the school by a responsible adult. Prescription medication must have a proper pharmacy label attached. Non-prescription medication must be in a new unopened container. All medications shall be kept in a locked cabinet in the nurse's office.

***Inhalers may be kept with student if noted by physician below.**

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER
(If non-prescription medication, parent must fill out)

Name of medication: _____ Reason for medication: _____

Form of medication/treatment:
☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ G-Tube ☐ Other _____

Schedule: [Time(s) of administration]: _____ **Dosage: _____**

Start: ☐ Date form & medication received by school nurse
Stop: ☐ End of school year Other date/duration: _____
☐ For episodic/emergency events only

School Nurse Use Only
Date Received: _____

Restrictions and/or important side effects: ☐ None anticipated ☐ Yes
If yes, please describe: _____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other: _____

This student is both capable and responsible for assisted self-administration of this medication:
☐ No (Nurse must administer) ☐ Yes-Supervised by nurse or trained teacher/principal/assistant
☐ Student may carry this medication (Emergency medications only)

Date: _____ Physician's Signature: _____

Physician's Name: _____ Phone Number:_____

Address: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child to receive the above medication during the school day assisted by school personnel as necessary. My child is both capable and responsible to self-administer this medication with assistance. ☐ Yes ☐ No, please report concerns about medications or disease to the above physician and myself.

Date: _____ Parent Signature: _____

Emergency Phone Numbers: _____