Norman Park Elementary School
"Today's learners. . .Tomorrow's leaders"

Norman Park Elementary School

249 West Weeks Street, Norman Park, Georgia 31771 (229) 769-3612

Phone (229) 769-3612
Fax (229) 769-5003

REQUEST FOR ADMINISTRATION OF MEDICATION

If this form is properly completed and returned to the school nurse, the Colquitt County School System may assist parents when their child's physician has prescribed medication for the child. The medication will only be given if it is delivered to the nurse or his/her designee in the original bottle marked with the student's name, dosage, time of administration, physician, pharmacy, and the date of expiration.

Student's Name _____ DOB_____

School _____ Grade_____ Teacher_____

STATEMENT OF PHYSICIAN

Medication _____ Date of Prescription_____

Number or amount of medication received: _____ **Dosage to be given**_____

Time(s) to be given at school: _____ Discontinue medication on _____

Allergies: _____

Diagnosis: _____

Possible medication side effects: _____

Action to be taken by school if any side effects: _____

Other medication the student is taking: _____

Other instructions: _____

Physicians Signature: _____

Physician's Address/Phone: _____

_____

Statement of Parent/Guardian

As the parent/guardian of the above named student, I do hereby request the school system give medication to the above named student at the times listed below. I understand that the school system is not legally obliged to administer medication to the student. School personnel will administer the medication. I agree not to institute suite against the school system for the administration or non-administration of the medication, to defend and hold the school system harmless from any liability resulting from the administration or non-administration of the medication, and to defend and indemnify the school system and its employees from any liability arising out of this agreement. I understand that it is my responsibility to notify the school nurse or designated health personnel immediately concerning any medication changes. As the parent/guardian I also authorize the prescribing physician named above to discuss with the principal or his/her designated staff member any matter regarding the medication to be administered or treatment to be performed. I also authorize the school to monitor the effectiveness of ADD/ADHD medication with the above listed physician via the ADD/ADHD Questionnaire.

Time(s) to be given at school: _____

Signature of Parent/Guardian_____ Date: _____

Home Phone: _____ Work Phone: _____