



## GWINNETT COUNTY PUBLIC SCHOOLS ADMINISTRATION OF MEDICATION REQUEST

STUDENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
STUDENT NUMBER: \_\_\_\_\_ TEACHER: \_\_\_\_\_  
SCHOOL: \_\_\_\_\_

**For the safety of all students at our school, these guidelines should be followed:**

1. Administration of prescription and over-the-counter medicine (even for a short period of time) is discouraged. Parents should check with their physician regarding the need for medications to be administered during school hours. Medications prescribed for three times daily often can be given before school, after school, and at bedtime. If you have any questions about this procedure, please call the school clinic.
2. All medications, both prescription and over-the-counter, must be accompanied by this form and brought to the school clinic by an adult.
3. All medications must be in the ORIGINAL CHILD PROOF CONTAINER. Prescription medications must be in the labeled prescription bottle. Pharmacists can give a duplicate labeled container with only the school dose. Medications stored in envelopes, baggies, etc. will not be administered.
4. It is the responsibility of the parent/guardian to inform the school of any changes and provide updated administration request forms to the school.
5. Medications must be picked up at the end of the year or the school will dispose of them.

**Please complete the following information:**

Name of Medication \_\_\_\_\_

Diagnosis for which medication was prescribed \_\_\_\_\_

Amount to be given (dosage) \_\_\_\_\_

Time(s) medication should be given at school \_\_\_\_\_

Possible side effects/Special Instructions \_\_\_\_\_

Expiration date \_\_\_\_\_

I, \_\_\_\_\_ (parent name), grant permission for the principal or designee to assist in the administration of the medication listed above for my child, \_\_\_\_\_, while at school or at school-sponsored activities. I understand that the school personnel cannot assure that anything more than a reasonable effort will be made to assist the student and I further agree to waive any claims of liability that may rise against any school personnel related to the administration of this medication to my child according to the instructions provided above.

Parent Name (printed) \_\_\_\_\_

Phone Contacts: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date