**DEKALB COUNTY SCHOOL DISTRICT**
**STUDENT HEALTH SERVICES**

# PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION IN THE 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. For medication to be self-administered at school, this form must be completed by a licensed physician and at least one guardian/parent and be returned to school.

School: _____

Name of Child: _____ Date of Birth: _____

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 7/11/22