

DEKALB COUNTY SCHOOLS
STUDENT HEALTH SERVICES

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION
IN SCHOOL BUILDING DURING SCHOOL HOURS

Must be Completed Annually/ One Medication per Form

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. In order for medication to be self administered at school, this form must be completed by licensed physician and at least one guardian/parent and be returned to school.

School: _____

Name of child: _____ DOB _____

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 will be destroyed.

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