GEORGIA SCHOOL FOR INNOVATION AND THE CLASSICS

Medication Administration Permission Form

Student _____ DOB _____/_____/_____

Grade _____ Homeroom Teacher _____

Name of medication _____

Reason for medication _____

Form of medication/treatment

[ ] Tablet/Capsule [ ] Inhaler [ ] Injection [ ] Nebulizer [ ] Liquid [ ] Other _____

Time to be administered at school _____ Dose to be administered _____

If PRN, list symptoms/conditions under which to administer medication

_____

Special Instructions _____

Restrictions and/or Side Effects

[ ] None Anticipated [ ] Yes, Please describe _____

Start [ ] Date form received [ ] Other Date _____/_____/_____

Stop [ ] End of school year [ ] Other Date/Duration _____/_____/_____

Physician's Name _____ Phone Number _____

Physician's Signature _____ Date _____/_____/_____

Only required for Injectable Medications

I request that my child, _____ receive the above medication at school according to standard school policy and for the physician, staff, and school staff to share necessary information needed to ensure my child's health and medication needs are met.

Parent/Guardian Signature _____ Date _____/_____/_____

Parent/Guardian Phone Number _____