Exhibit
Medicines

Descriptor Code
JGCD-E

DEKALB COUNTY SCHOOLS
STUDENT HEALTH SERVICES

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION IN 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. 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 within one week will be destroyed.

Revised 3/22/11