Authorization to Administer Medication to Student during School Hours

I. Parent/Legal Guardian's Statement

I hereby request that the Atlanta Girls' School, through its designated authority, supervise/assist in the

administration of medication to my daughter,____
according to the instructions outlined below. I understand that a physician must complete the Medication Details section of this authorization for prescription medications. I also understand that only the physician may alter dosage and times for prescription medication. I release the Board of Trustees, the school, and any school employee from liability for administering any authorized medication.

____ ____________________________

Parent or Legal Guardian's Signature Date

II. Medication Details

This section must be completed and signed by a physician if authorization is for prescription medication. Parents / Guardians must complete this section for non-prescription medication.

Type of medication: ☐ Prescription(This section must be completed by a physician for prescription medication.)
☐ Non-Prescription

Name of medication: ____

Reason for medication (optional): ____

Exact Dosage: ______________ Time(s) medication is to be administered during the school day ____________________

Time period for administration of medication: _____________________________

☐ Entire school year ☐ Until finished ☐ Other: __________________________

Possible side effects: ____

____

Suggested first aid for side effects: ____

____

Is this medication for an allergy? ☐Yes ☐ No If"Yes,"is the allergy lifethreatening? ☐ Yes ☐ No
Allergy to: ____

Date of last allergic reaction: _______________ What medication or action was taken? __________________

Emergency plan for allergic reaction during school hours:

____

____

Students with a life-threatening allergy are permitted to carry an Epi-Pen. Parents of students with a life- threatening allergy are encouraged to supply an extra Epi-Pen to the Infirmary.

____ _______________________________

Physician's Name (Printed)
Required for Prescription Medication

Physician's Phone Number

____ _______________________________

Physician's Signature
Required for Prescription Medication

Date