COBB COUNTY SCHOOL DISTRICT

Empowering Dreams for the Future

Form JGCD-2

AUTHORIZATION TO GIVE MEDICATION

If medication can be given at home, before or after school hours, please do so. If medication must be given during school hours, this Form must be completed and filed with the School Clinic.

STUDENT'S NAME: _____

TEACHER: _____ **GRADE:** _____

I authorize the Cobb County School District to assist my child in taking this medication. I understand that:

- Medications must be in the original labeled container. Pharmacists may provide two labeled bottles for this purpose. Medications sent in an unlabeled container will not be given. If your child takes daily medication, please send an extra bottle to be used for field trips and After School Program.
- Written permission of the parent/guardian is required for the administration of all medications.
- The parent/guardian must inform the school of any medication changes. New medication or new doses will not be given unless a new form is completed.
- Medications must be brought to the office/clinic by the parent/guardian.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued. If medication is given throughout the school year, medication will be disposed of according to the medication Rule Section IX.

NAME OF MEDICATION: _____

DOSE: _____ ROUTE*: _____ TIME(S) to be given: _____

DATE TO DISCONTINUE MEDICATION: _____

CONDITION/ILLNESS REQUIRING MEDICATION: _____

POSSIBLE SIDE EFFECTS, IF ANY: _____

Licensed Health Care Provider: _____

Licensed Health Care Provider's Phone: _____

I hereby release and discharge and further agree to indemnify, hold harmless, or reimburse the Cobb County Board of Education, the Cobb County School District, its employees, agents, representatives, and all other officials, from any and all claims, actions, suits, losses, costs, expenses and liability in case of accident or any other mishap because of negligence in administering such medication or because of side effects, illness or any other injury which might occur to my child through administering such medication. And, I hereby release said aforementioned board, district, employees and officials from any liability, suit or claims of whatever nature and kind, which might arise as a result of administering the medication in accord with this request.

_____ _____

Parent/Guardian Signature Date

Home Phone: _____ **Work Phone:** _____ **Pager/ Cell Phone:** _____

*Route: The method that medication is administered, such as by mouth, injection, inhaler, rectum, etc.

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Form JGCD-7

AUTHORIZATION TO CARRY OVER-THE-COUNTER MEDICATION

Complete this form to allow Elementary and Middle School Students to carry certain over-the-counter (OTC) medications. Elementary School students (grades K-5) may carry cough and throat lozenges. Middle School students (grades 6-8) may carry certain (OTC) medications: Tylenol, acetaminophen, Motrin, Advil, ibuprofen, Midol, aspirin, antacid, cough and throat lozenges and oral antihistamines. All prescription medication, cough and cold medication (except lozenges), antihistamines, and (OTC) medication not listed above shall be kept in the clinic. The student and parent/guardian will be responsible for the following:

1. Obtaining, reading and signing this written permission form before the student is allowed to carry the medication.
2. Ensuring the medication is in its original container and legibly labeled with the student's full name.
3. Reminding the student he/she is not permitted to give his/her medication to other students.
4. Ensuring that the School Nurse has a copy of this signed permission form on file in the clinic and the student carries a copy of the signed form with the medication.

Date: _____

Student: _____

Name of Medication: _____

I hereby release and discharge and further agree to indemnify, hold harmless, or reimburse the Cobb County Board of Education, the Cobb County School District, its employees, agents, representatives, and all other officials, from any and all claims, actions, suits, losses, costs, expenses and liability in case of accident or any other mishap because of negligence in administering such medication or because of side effects, illness or any other injury which might occur to my child through administering such medication. And, I hereby release said aforementioned board, district, employees and officials from any liability, suit or claims of whatever nature and kind, which might arise as a result of administering the medication in accord with this request. I accept legal responsibility for my child should the above medication be lost, given or taken by a person other than the above named student. If this should happen, the privilege of carrying medication will be revoked. I further release the Cobb County School District and its employees of any legal responsibility when the above student administers his/her own medication.

_____ _____

Date Signature of Parent/Guardian

I understand how much and when to take the above named medication. I will not allow another student to take my medication under any circumstances. I also understand that should another student take my medication, the privilege of carrying my own medication shall be taken away and I will be subject to the consequences specified in the code of conduct.

_____ _____

Date Signature of Student

I have seen the above labeled medication bottle and have a copy of this permission form.

_____ _____

Date Signature of School Nurse

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Form JGCD-10

AUTHORIZATION TO CARRY PRESCRIPTION MEDICATION

_____ needs to carry the following prescription asthma medication, epinephrine auto injector or diabetic medication with him/her. The above named student has been instructed in the proper use of the medication and fully understands how to administer this medication. (It is preferable that additional asthma medication, epinephrine auto injectors, or diabetic medication be kept in the clinic in case the first is lost or left at home.)

Medication	Dosage and Directions
Licensed Health Care Provider's Signature & Stamp	Date

I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that I will be subject to the consequences of the code of conduct should another student use my prescription. I also accept the responsibility for checking in with the School Nurse to keep her informed of use of my medication in case I start having problems.

Student's Signature	Date

I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above, at school. I hereby release and discharge and further agree to indemnify, hold harmless, or reimburse the Cobb County Board of Education, the Cobb County School District, its employees, agents, representatives, and all other officials, from any and all claims, actions, suits, losses, costs, expenses and liability in case of accident or any other mishap because of negligence in administering such medication or because of side effects, illness or any other injury which might occur to my child through administering such medication. And, I hereby release said aforementioned board, district, employees and officials from any liability, suit or claims of whatever nature and kind, which might arise as a result of administering the medication in accord with this request. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the Cobb County School District and its employees of any legal responsibility when the above named student administers his/her own medication. I further provide a release for the school nurse or other designated school personnel to consult with the physician regarding any questions that may arise with regard to the medication.

Parent/Guardian Signature	Date