Clarksville-Montgomery County School System

20____ - 20___School Year

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

PLEASE NOTE **:** Medications must be brought to and picked up from school by a parent/guardian or his/her adult designee. Children may not bring medication to school or take medication home unless it is an emergency rescue medication that must remain with the student at all times. Prescription Medication must be in a properly labeled prescription bottle with the student's name, pharmacy name and phone number, date (within current school year), prescriber's name, name of medication, dose and frequency imprinted on the pharmacy label. Over the Counter Medication must be in the manufacturer's original and unopened container which shows a list of ingredients.

The following section is to be completed by the PARENT/GUARDIAN:

School:	**Student's Name:**	**Date of Birth:**

I request that my child be assisted in taking medication, described below, at school by legally authorized persons or permitted to medicate himself/herself as also authorized by my child's physician. I also give my permission for school personnel to contact my child's physician.

I, _____, will assume any and all responsibility and liability for any problems
parent/guardian's printed name
with my child taking this medication at school. I release CMCSS and its personnel from any legal claims which they have now, or thereafter have, arising out of medication taken while at school.

_____ _____ (____)_____ (____)_____

Date **Parent/Guardian Signature** **Home Phone** **Emergency Phone**

The following section is to be completed by the PHYSICIAN for prescription medications or by PARENT/GUARDIAN for Over the Counter Medications

Name of Medication:

Diagnosis for which medication is prescribed:

Route:	**Dose:**

If medication is to be given daily, at what time? (please consider alternate dosing schedule to minimize medication in school)

If medication is to be given "when needed" describe indications:

How soon can it be repeated?	**Length of time treatment recommended?** **___Current School Year ___Other:_____**

List significant side effects:

Provider to initial yes or no for each of the following:
Is student permitted to carry and self-administer emergency rescue medication? _____ **YES** _____ **NO**
Has student been instructed in self administration of prescribed rescue medication? _____ **YES** _____ **NO**

Date **Physician's Signature**

Physician's Name, Address and Phone Number: