COLQUITT COUNTY SCHOOL DISTRICT
REQUEST FOR ADMINISTRATION OF MEDICATION

If this form is properly completed and returned to the school nurse, the Colquitt County School District may assist parents when their child's physician has prescribed medication for the child. The medication will only be given if it is delivered to the nurse or his/her designee in the original bottle marked with the student's name, dosage, time of administration, physician, pharmacy, and the date of expiration.

Student's Name _____ DOB_____ FTE or SS #_____

School _____ Grade_____ Teacher _____

STATEMENT/ ORDER OF PHYSICIAN

Medication _____ Date of Prescription_____

Number or amount of medication received: _____ **Dosage to be given**_____

Time(s) to be given at school: _____ Discontinue medication on _____

Allergies: _____ Diagnosis: _____

Possible medication side effects: _____

Action to be taken by school if any side effects: _____

Other medication the student is taking: _____

Other instructions: _____
Physicians Signature: _____ Date _____

Physician's Address: _____ Phone: _____

STATEMENT of PARENT/GUARDIAN

As the parent/guardian of the above-named student, I do hereby request the school district give medication to the above-named student at the times listed below. I understand that the school district is not legally obliged to administer medication to the student. School personnel will administer the medication. I agree not to institute suit against the school district for the administration or non-administration of the medication, to defend and hold the school district harmless from any liability resulting from the administration or non-administration of the medication, and to defend and indemnify the school district and its employees from any liability arising out of this agreement. I understand that it is my responsibility to notify the school nurse or designated health personnel immediately concerning any medication changes. As the parent/guardian, I also authorize the prescribing physician named above to discuss with the principal or his/her designated staff member any matter regarding the medication to be administered or treatment to be performed.

Time(s) to be given at school: _____

Signature of Parent/Guardian_____ Date: _____

Home Phone: _____ Work Phone: _____

SERVICE PLAN for SCHOOL-BASED MEDICAID SERVICES

My child is eligible for Medicaid or Peachcare YES___ NO___ Number _____

My child is receiving Special Ed. Services YES __ NO__ Nursing is in the IEP _____ Other Health Plan _____

I understand that the school district is able to file with Medicaid or Peachcare for partial reimbursement for the administering of this medication or procedure. By signing below, I give my consent for the school district to receive this payment from Medicaid or Peachcare.

I have read this form and understand my responsibility toward the school, which is agreeing to assist me in this matter of medicating/treating my child at school. I may change/withdraw permission in writing at any time by notifying the Special Education Director.

The undersigned authorizes the prescribing physician named below to release any information to the School Board or their designee regarding the medication/treatment to be administered. I, the undersigned, authorize the Colquitt County Schools to release pertinent information to the physician

_____ _____

Signature of Parent/Guardian **Date**