Request for Assistive Administration of Medication

If this form **must** be properly completed and returned to the school principal/clinic aide, the Tift County School System can assist students in taking their medication during school hours.

- **Tift County Schools does not provide medication for students. Parents are responsible for purchasing and delivering all over-the-counter medications (Tylenol, ibuprofen, Pepto Bismol, Benadryl, etc.) to the school.**
- **The medication will only be given if it is delivered to the principal or clinic aide in the original bottle marked with the student's name, dosage, time of administration, physician, pharmacy, and date of purchase.**
- **Parent/guardian must provide specific instructions, as well as the medication and related equipment.**
- **It is the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed.**
- **All medication will be taken directly to the school office or clinic by the parent.**
- **Unused medication will be disposed of unless the parent/guardian picks it up within one week after medication is discontinued, or at the end of the school year.**
- **A new medication request must be provided to the school each school year and with each new medication.**

Name of Student: _____ Birthdate: _____

School: _____ Grade: _____

Non-Routine medication that may be needed during the school day (Tylenol, Advil, Aleve): _____
Dose _____

This medication is **NECESSARY** for school attendance.

Prescription Medication to be given at School _____

Date of Prescription: _____ Pharmacy used: _____

Physician's Name: _____ Physician's Phone # _____

Dosage and Time of Administration at school: _____

Discontinue medication on: _____

Allergies: _____

_____ medication is to be given as needed (Asthma inhaler, Epi-Pen, or insulin). This student has been trained in its use and **may carry this specified medication at all times.**

Illness requiring medication: _____

Possible medication side effects: _____

Other medication the student is taking: _____

Physician's Name and address: _____ _____

Statement of Parent/Guardian

As parent/guardian of the above named student, I do hereby request the school system to give medication to the above-named student. I understand that the school system is not legally obligated to administer medication to the student. I will notify the school principal and/or clinic aide immediately in writing if the medication is changed. **I understand that if this medication or dosage is changed or discontinued, a new** Request for Assistive Administration of Medication form **must be obtained. I also consent to the sharing of necessary medical information between my child's physician and/or pharmacist and the designated provider of healthcare services in the school setting.** *(If you have read and agree with these terms, sign and date below:*

Parent/Guardian signature: _____ Date: _____

****Check here if you would like to schedule an appointment with the Clinic Aide or Nurse Supervisor to discuss your child's medication or medical condition. ☐ Yes ☐ No**