ATLANTA SPEECH SCHOOL
REQUEST AND CONSENT FOR MEDICATION ADMINISTRATION

Child's Name:_____ Birth Date:_____ Teacher:_____

Parents/Guardians: A separate **Request and Consent for Medication Administration Form** must be completed for all medications to be administered at school and home and each time a change is made in medication, dosage or time of administration. It is vital that we have an accurate record of all medication a child is taking, even medication not administered at school.

I understand that:

- It is my responsibility to notify the school (nurse and/or teacher) in writing of any discontinuance or other change in medication or dosage, even if the change affects only a medication given at home.
- Prescription medication must be in a current labeled pharmacy container with the child's name, medication, dosage, directions for administration, pharmacy name, pharmacy phone number, and name of physician prescribing the medication on the label.
- Medication, whether prescription or over-the-counter, must be delivered by a parent directly to the school nurse. **Students may not have medication in their possession, except with a physician's written request.**
- If dosage requires a half-pill, pills must be cut before medication is brought to the school.
- The school will not store more than a one-month supply of medication at any time.

I hereby give to the Atlanta Speech School and its designated employees and agents permission to supervise my child in taking the medication listed below in accordance with the dosage and other instructions given below.

I hereby certify that at least one dose of the following medication has been given to my child and that there was no adverse reaction from it.

I hereby give the Atlanta Speech School and its employees and agents permission to contact my child's healthcare providers and pharmacies to acquire medical information concerning my child's diagnosis, medication and medical treatment, and I hereby give such providers and pharmacies permission to disclose such information to the Atlanta Speech School and its employees and agents.

I hereby release and agree to hold harmless the Atlanta Speech School and its employees and agents from any and all liability in case of accident, injury, damage or other mishap, including, without limitation, any side effect, illness or other injury, that might occur to my child in connection with administration and supervision of the following medication in accordance with the instructions below:

_____ _____ _____

Parent/Guardian Signature Telephone Number Date

Physician's recommended dosage, method of administration and other instructions:

	NAME (please list **all** medication being taken, even if only administered at home)	Prescription number	TIME medication is to be administered. Please also list time given at home.	DOSAGE (in milligrams) and method of administration	Purpose of the medication	Should **mid-day** medication be administered on 12:45 p.m. dismissal days?	Beginning Trial Date **(If Applicable)**	Ending Trial Date **(If Applicable)**
A.M.								
Mid-day						☐ Yes ☐ No		
						☐ Yes ☐ No		
P.M.						What time to remove patch?		

Other instructions for administration:_____

Possible side effects and recommended action:_____

_____ _____ _____

Print Physician's Name Physician's Signature Date

Physician's Phone Number:_____ Physician's Fax Number:_____

Revised 06/04/10