

Fayette County School Health Services  
**SCHOOL MEDICATION AUTHORIZATION**

Please bring or mail this School Medication Authorization to the school or send to the secure FAX at 770-460-3928.

Student's Name: _____	Birth Date: _____	
School: _____	Grade: _____	Homeroom Teacher: _____
List any drug allergies/reactions: _____		

**PARENT OR LEGAL GUARDIAN AUTHORIZATION**

***(Required for ALL Medications)***

If medications must be given during school hours, this form must be completed. The parent/guardian must provide the school with the over-the-counter or prescription or homeopathic/supplement medication in the original container with unexpired date and will be given as directed on the package or as directed by the below physician. It is the responsibility of the parent/guardian to notify the school of medication changes and complete a new Authorization.

**Name of Medication:** \_\_\_\_\_  Daily OR  As Needed

**Dosage:** \_\_\_\_\_ **Frequency/Times to be Given:** \_\_\_\_\_ **Medication Expiration Date:** \_\_\_\_\_

**Medication for:**  This School Year 20\_\_ - 20\_\_  Following Dates Only \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

*I, this child's parent/guardian, hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's medication and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Fayette County Schools. This authorization expires as of the last day of the school year.*

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► **Parent/Legal Guardian Signature** ◀ \_\_\_\_\_ **Date** \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

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**PHYSICIAN AUTHORIZATION**

***(Required for Prescription or Homeopathic OR Supplement Medications ONLY)***

**Name of Medication:** \_\_\_\_\_

**Dosage:** \_\_\_\_\_ **Route:** \_\_\_\_\_ **Frequency/Time to be Given:** \_\_\_\_\_

**Start Medication On:** \_\_\_\_\_ **Stop Medication On:** \_\_\_\_\_

**Condition/Illness Requiring Medication:** \_\_\_\_\_

**Common Side Effects of the Medication:** \_\_\_\_\_

**Student may carry and self-administer medication due to a life threatening condition:**  Yes  No

**Special Instructions:** \_\_\_\_\_

► **Physician's Signature** ◀ \_\_\_\_\_ **Date:** \_\_\_\_\_

**PRINT Physician's Name:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_