RCSS AUTHORIZATION TO GIVE MEDICATION AT SCHOOL - Pro-Longed Time Period

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed. Please write one medication per page.

Student: _____ School: _____

Homeroom Teacher: _____ Grade: _____

I request that _____ School, through the principal or designee to supervise/assist in the administering of medication to my child according to the instructions below. I understand that:

- Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacies can provide a duplicate labeled container with only the school doses.
- Parent/Guardian must provide special instructions, as well as the medication and related equipment, to the principal or clinic personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medications or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- All medications will be taken directly to the office/clinic by the parent/guardian.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

Name of medication: _____ Dose: _____

Route (mouth, topical, etc.): _____ Time(s) to be given: _____

Terminate medication on: _____

Physician's PRINTED Name: _____ Physician Phone: _____

Condition/Illness requiring medication: _____

Possible side effects, if any: _____

What to do in a case of side effect(s): _____

Allergies: Food: _____ Medication(s): _____

Signature of health care provider: _____ Date: _____

I hereby authorize the school personnel, employees and officials of the Richmond County School District to assist my child in taking prescribed medication according to district policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medication, I am responsible for completing a new request form.

Parent Signature & Date: _____

SERVICE PLAN for SCHOOL-BASED MEDICAID SERVICES

1. My child is eligible for Medicaid or Peach Care YES___ NO___ Number _____
2. **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 Peach Care 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 Peach Care.

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 or School Nurse

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 Richmond County Schools to release pertinent information to the physician.

Parent/Guardian Signature & Date: _____ _____