Youth Middle School

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www.youthmiddle.org

YMS ...where Young Minds Succeed
WARRIORS

Georgia Distinguished Middle School 2007 - 2011

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's Name: _____

Teacher: _____ Grade: _____

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

- Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacists can provide a duplicate labeled container with only the school doses.
- Parent/guardian must provide specific 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 medication or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- All medication will be taken directly to the office/clinic by the parent.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

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Name of Medication: _____

Dose _____ Route (by mouth, topical, etc) _____

Time(s) to be given _____ Stop Medication on: _____

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

I hereby authorize the personnel, employees and officials of the _____ 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 medicine, I am responsible for presenting a new request form.

_____

Parent/ Legal Guardian signature Date

Home Phone _____ Work Phone _____ Pager/Cell Phone _____

To be completed by your healthcare provider for prescription medications given for more than two weeks:

Condition/Illness Requiring Medication: _____

Possible Side Effects if any: _____

_____

Signature of Healthcare Provider Date

** ANY MEDICATION NOT PICKED UP PRIOR TO THE LAST DAY OF SCHOOL WILL BE DISCARDED. **

Daily (Control) Medication Counts

Year: ____________ Student Name: ____________________ Medication: ____________________

WEEK OF																																				
MON. AM																																				
MON. PM																																				
TUE. AM																																				
TUE. PM																																				
WES. AM																																				
WES. PM																																				
THU. AM																																				
THU. PM																																				
FRI. AM																																				
FRI. PM																																				

MEDICATION COUNT UPON RECEIPT:

MED NAME	DATE	BROUGHT BY	REC'D BY	QTY

COMMENTS:

DATE	COMMENT

Ch3-4b 2009