

How DeKalb County School System and D.A.T.E Administer Medications

The term "medication" means all legal substances including but not limited to prescription drugs, over-the-counter drugs, inhalants, pills, tablets, capsules, herbal medications, and all other legal drugs.

Any student required to take medication while at school must have a written authorization by the parent/guardian and physician.

Prescription medications must be properly labeled by a pharmacist and in the original container.

Non-prescription medication must be in the original container.

All medications must be personally delivered to the school nurse, Ms. Franklin, with a completed medication authorization form to: catherine_Franklin@fc.dekalb.k12.ga.us.

These procedures must be followed to avoid charges of negligence.

DeKalb County School System

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL BUILDING DURING SCHOOL HOURS

1. To keep this child in optional health and to help maintain school performance, it is necessary that medication be given during school hours.
2. Nurses and other designated school personnel can assist with self-administration of medication during school hours.
3. In order for medication to be self administered at school, this form must be completed by licensed physician and at least one guardian/parent and be returned to school
4. One form must be completed by a licensed physician and at least one guardian/parent for each prescription or non-prescription medication that is to be administered during school hours.

School: Date:

Name of Child: D.O.B.

Diagnosis: Infectious Noninfectious

Allergies _____

Name of Medication (include trade name):

Tablet Pill Capsule Liquid Inhalation Injection Other

Dosage: _____

Frequency _____

Common Side Effects: _____

Remarks: _____

PHYSICIAN'S INFORMATION:

Physician's Name (printed) Physician's Signature Date

Office #: Fax#:

I hereby give permission to The DeKalb Academy of Technology and Environment to administer medication to my child named above as requested by the physician.

Parent's Signature Date Home Phone# Cell Phone #

**DeKalb County School System
Student Health Information**

Student's Name:

Male Female (please circle one)

Birth Date:

Grade

School

Date:

Please check any of the following that applies to the student:

- ADD
- ADHD
- Allergies; Specific type _____
- Is EpiPen required? Yes No
- Asthma
- Reactive Airway
- Frequent Bronchitis
- Chemotherapy/Immunosuppression
- Cystic Fibrosis
- Depression
- Diabetes: Type 1 Type 2
- Eating Disorder
- Underweight
- Overweight
- Head Injuries
- Hearing Loss
- Heart Disease
- Hemophilia
- Hepatitis

- Hypertension
- Injury, Major
- Kidney Disease
- Leukemia
- Nosebleeds (frequent)
- Organ transplant
(Please circle: Liver/Heart/Kidney)
- Orthopedic Problems
- Migraine Headaches
- Muscular Dystrophy
- Pityriasis Rosea
- Pneumonia
- Psoriasis
- Rheumatic Fever
- Seizure Disorder
- Sickle Cell Anemia
- TB
- Vision Loss

If the student has any of the above, did he/she receive medical care? Yes No

Is the student under medical treatment now? Yes No

If yes, what kind of medical treatment?

Is the student on any kind of medication? Yes No

If yes, please list medication(s)

NOTE: Please see school health personnel for a Doctor/Parent Medication Permission Form.
A Physician MUST sign a form for EACH medication to be taken in school.

Parent/Guardian Signature

Phone Number

THIS INFORMATION IS CONFIDENTIAL AND OPTIONAL. PLEASE RETURN FORM TO CLINIC AT YOUR SCHOOL.