

*DeKalb County Eastern CSD*

Authorization for Administration of Medication at School

Student Name \_\_\_\_\_ Grade/Teacher \_\_\_\_\_

Medication Name on container \_\_\_\_\_ Dose \_\_\_\_\_

Time of day to be given \_\_\_\_\_ am/pm **OR** As needed

Medication expiration date listed on container \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ **OR** Over the counter

How taken (circle one): By mouth Inhaled Patch Other \_\_\_\_\_

Medical condition requiring medication \_\_\_\_\_

Date medication to be discontinued \_\_\_\_\_

Other medications taken at home \_\_\_\_\_

*\*\* Note: It is the responsibility of the parent/guardian to cut tablets of medication (if necessary) before sending to school.  
The school will dispose of any medication left after the close of the school year.*

**Instruction for School Delays**

\_\_\_\_\_ My child will take his/her medication at the regularly scheduled time indicated above.

\_\_\_\_\_ Special arrangements need to be followed.

Those arrangements include: \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**MEDICATION RETURN INFORMATION** (completed only at the time medication is returned to parent/guardian)

This is to certify that I picked up my child's medication listed above.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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