COBB COUNTY SCHOOL DISTRICT
Empowering Dreams for the Future

Form JGCD-2

AUTHORIZATION TO GIVE MEDICATION

If medication can be given at home, before or after school hours, please do so. If medication must be given during school hours, this Form must be completed and filed with the medication in original pharmacy bottle to the Lead Chaperone, Tracy Duke**,** cell 626 841-8424.

STUDENT'S NAME: _____

TEACHER: _____ **GRADE:** _____

I authorize the Cobb County School District to assist my child in taking this medication. I understand that:

- Medications must be in the original labeled contain. Pharmacists may provide two labeled bottles for this purpose. Medications sent in an unlabeled container will not be given.
- Written permission of the parent/guardian is required for the administration of all medications.
- The parent/guardian must inform the school of any medication changes. New medication or new doses will not be given unless a new form is completed.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued. If medication is given throughout the school year, medication will be disposed of according to the medication Rule Section IX.

NAME OF MEDICATION: _____

DOSE: _____ ROUTE*: _____ TIME(S) to be given: _____

DATE TO DISCONTINUE MEDICATION: _____

CONDITION/ILLNESS REQUIRING MEDICATION: _____

POSSIBLE SIDE EFFECTS, IF ANY: _____

Licensed Health Care Provider: _____

Licensed Health Care Provider's Phone: _____

I hereby release and discharge and further agree to indemnify, hold harmless, or reimburse the Cobb County Board of Education, the Cobb County School District, its employees, agents, representatives, and all other officials, from any and all claims, actions, suits, losses, costs, expenses and liability in case of accident or any other mishap because of negligence in administering such medication or because of side effects, illness or any other injury which might occur to my child through administering such medication. And, I hereby release said aforementioned board, district, employees and officials from any liability, suit or claims of whatever nature and kind, which might arise as a result of administering the medication in accord with this request.

_____ _____

Parent/Guardian Signature Date

Home Phone: _____ **Work Phone:** _____ **Pager/ Cell Phone:** _____

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*Route: The method that medication is administered, such as by mouth, injection, inhaler, rectum, etc.