Home Room Teacher_____

Phone: 770-615-3680 * 3264 Brookmont Pkwy – Douglasville, GA 30135 * Fax: 770-615-3677

MEDICINES

ASSISTANCE WITH MEDICATION

Child's Name_____ School_____

Address_____ Home Phone_____

Mother's Name_____ Day Phone_____

Father's Name_____ Day Phone_____

Physician's Name_____ Phone_____

Emergency Contact_____ Phone_____

All medication must be placed in an original container. Check with your pharmacist if you need a duplicate bottle. Medication not claimed at the end of the school year will be discarded.

Name of Medication_____

Time to be given_____

Dosage_____

Side effects_____

Termination date for administering medication_____

I hereby authorize the personnel of the Douglas County School District to assist my child in taking medication. I understand that in the event of a change in medication, the parent/guardian is responsible for completing a new request form.

_____

Parent/Guardian Signature Date

_____

Physician's Signature (if possible to obtain) Date

ADOPTED: 3/16/98
REVISED: 8/3/12

Douglas County Board of Education