DAVIDSON COUNTY, LEXINGTON CITY, AND THOMASVILLE CITY SCHOOLS
MEDICATION FORM

Child's Name: _____ **Birthdate:** _____ **School:** _____

Parent/Guardian:
The administration of medication at school is discouraged. However, if medication must be taken while at school, authorization and specific instructions must be on file at school. All school administered medication must be sent to school in the original container and appropriately labeled.

Non-prescription medication – Parents/Guardians should complete Section A and Section C below and return this form to school with the medication. All school administered medication must be sent to school in original containers and appropriately labeled containers.

Prescription medication – Parents/Guardians should complete Section B and Section C of this form. The prescribing physician must sign and date the form. The form must then be returned to school with the medication. All school administered medications must be sent to school in original containers and appropriately labeled containers.

Section A: Non-Prescription Medication

I request and give permission for the school to administer the listed medication to be given during school hours. I hereby release the School board, and their agents and employees from any and all liability that may result from the administration of the medication. I understand the Medication Form must be correctly completed and medication must be brought to school in the original container and appropriately labeled.

_____
Signature of Parent/Guardian

_____ _____
Date Telephone Number

Medication (include trade name): _____

Form of Medication: (Circle) Pill/Tablet Topical Ointment
Liquid Describe color _____

Dosage: Amount to administer _____

Times to be given: _____
Relationship to meals: _____

Section B: Prescription Medication

I request and give permission for the school to administer the listed prescription medication to be administered to my child during school hours. I hereby release the School Board, its agents and employees from all liability that may result from the administration of the listed medication. I understand the Medication Form must be correctly completed including the prescribing physician's signature and must be brought to school in the original container and appropriately labeled.

_____
Signature of Parent/Guardian

_____ _____
Date Telephone Number

Medication: _____
Include Trade Name and Prescription Number

Form of Medication: Pill/Tablet Topical Ointment
Liquid Describe Color: _____

Dosage: Amount to administer: _____
Relationship to meals: _____

Side Effects: _____
Instructions should side effects occur: _____

Contraindications for Administration: _____

_____
Physician's Signature

_____ _____
Telephone Number Date

Section C: Medical Release Information

I, parent/guardian, of _____

authorize my physician, _____

to release significant information regarding my child's health care to the school for the _____ school year.

_____ _____
Parent/Guardian Signature Date