HALL COUNTY SCHOOL SYSTEM

Gainesville, Georgia

Teacher / Grade_____

School Year:_____

HEALTH CARE PROVIDER / MEDICATION PERMISSION FORM

(This form, and the "Parent/Guardian Medication Permission Form," must be completed before physician-prescribed medication can be administered to a student at school.)

Dear Health Care Provider,

The school has been notified that _____ is on medication and will need to take it during school hours at school. We request that you fill out this form for each medication prescribed for the above mentioned child and keep us updated on medication dosage and/or treatment changes.

We also ask for your assistance in helping us with the large amount of medication that is being given at school. We request that if there is medication that can be given at home instead of at school that the parent/guardian be encouraged to do so.

Concerning medication packaging, we request that you ask the pharmacist to give the parent/guardian two labeled containers of medication as well as written information of the proper use of the medication, if available. The parent/guardian will then have one container of medication at home and one at school.

Your assistance with this is greatly appreciated. Thank you.

Birthdate: _____ School: _____ Grade:_____ **Student's Name**: _____

1. **Child's complaint, duration and severity**: _____
2. **Diagnosis**: _____
3. **Medication Prescribed**: _____ Dosage: _____
   Route of Administration:_____ Time to be given during the day:_____ Duration:_____
4. List any **possible adverse side effects or reactions** that may be anticipated:_____
   _____
5. List any **restrictions in the classroom or level of activity** (include recess/playground activity and Physical Education):
   _____
   _____
6. List any **special diet restrictions or considerations**:_____
   _____
7. Give a brief outline of **emergency management for school personnel**: _____
   _____
   _____
8. Briefly outline the **child's health care issues that may affect school planning**:_____
   _____
9. List **specific training required** for school personnel to assist with the administration of the above medication:
   _____
   _____

_____ _____

Health Care Provider Signature Date

_____ _____

Health Care Provider Address Health Care Provider Telephone

Revised: August 2002