QUITMAN SCHOOL DISTRICT
AUTHORIZATION FOR ADMINISTRATION OF ANY MEDICATION
2020 - 2021
PHYSICIAN'S SIGNATURE AND PARENT'S SIGNATURE ARE REQUIRED FOR ALL MEDICATION

STUDENT'S NAME:_____ DOB:_____DATE: _____
SCHOOL: ___Lower Elementary ___Upper Elementary ___ Junior High ___ High School
GRADE: _____ Homeroom Teacher _____

Is child allergic to any medications? ___ YES ___ NO
If yes, please list: _____

As the parent/guardian of the student named above, I request that the principal/principal's designee administer the prescription medication described below to my child.
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This section is to be completed by physician or primary care provider

Name of Medication: _____

Dosage to be given: _____ Time to be given: _____ Date to Start: _____

Health condition requiring medication: _____

Possible side effects/special instructions: _____

Name of primary care provider prescribing medication: _____
Phone: _____

The child named in this form is authorized to carry an asthma inhaler on his/her person.__ YES__NO

**Physician's Signature: _____ Date signed: _____
Name of Pharmacy: _____

Date to discontinue or review administration of medication: _____

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___I understand that school personnel cannot be held liable for reaction or side effects from the administration of the medication. I grant permission for school personnel to contact the physician if there are urgent questions or concerns about the medication.

___ I give permission for the school's designee to administer the medication to my child as prescribed above. All controlled substance will be counted and signed for. **NO MEDICATIONS WILL BE PROVIDED BY SCHOOL.**

**Signature of parent/guardian: _____ Date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

This form must be completed in its entirety in order for any medication to be dispensed to the student listed above.

HEALTH INFORMATION SHEET
QUITMAN SCHOOL DISTRICT
2020 - 2021

The information provided on this sheet will help us care for your child while he/she is at school.

Student Name: _____Parent/Guardian: _____

Phone Number where you can be reached during the day by the School Nurse: _____

Has a medical doctor ever diagnosed your child with:

___Asthma ___ ADD/ADHD ___ Cerebral Palsy ___ Diabetes

___ Hypertension ___ Seizures ___ Heart Condition

___ Depression/Anxiety ___ Other Medical Conditions (list):
_____
_____

Does your child take DAILY Medication?
___ NO
___ YES (Name of Medication) _____
___ Given at Home
___ Given at School? If yes, a doctor's order must be attached for prescription medications.

Does your child have medication allergies: ____ NO ____ YES If yes, what is the name of the medication he/she is allergic to? _____

Does your child have any food allergies: ____NO ___YES, if yes, what are the foods he/she is allergic to?
_____

Does your child wear glasses or contacts: ___ NO ___ YES

Does your child wear hearing aids or hearing devices: ___ NO ___ YES