How DeKalb County School System and D.A.T.E Administer Medications

The term "medication" means all legal substances including but not limited to prescription drugs, over-the-counter drugs, inhalants, pills, tablets, capsules, herbal medications, and all other legal drugs.

Any student required to take medication while at school must have a written authorization by the parent/guardian and physician.

Prescription medications must be properly labeled by a pharmacist and in the original container.

Non-prescription medication must be in the original container.

All medications must be personally delivered to the school nurse, Ms. Franklin, with a completed medication authorization form to: catherine_Franklin@fc.dekalb.k12.ga.us.

These procedures must be followed to avoid charges of negligence.

DeKalb County School System

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL BUILDING DURING SCHOOL HOURS

1. **To keep this child in optional health and to help maintain school performance, it is necessary that medication be given during school hours.**
2. **Nurses and other designated school personnel can assist with self-administration of medication during school hours.**
3. **In order for medication to be self administered at school, this form must be completed by licensed physician and at least one guardian/parent and be returned to school**
4. **One form must be completed by a licensed physician and at least one guardian/parent for each prescription or non-prescription medication that is to be administered during school hours.**

School: DeKalb Academy of Technology and Environment **Date:** / /

Name of Child: **D.O.B.** / /

Diagnosis: ◯ **Infectious** ☐ **Noninfectious** ◯

Allergies _____

_____

Name of Medication (include trade name): _____

Tablet ◯ **Pill** ◯ ☐ **Capsule** ◯ ☐ **Liquid** ◯ ☐ **Inhalation** ◯ ☐ **Injection** ◯ ☐ **Other** ◯

Dosage: _____

Frequency _____

Common Side Effects: _____

Remarks: _____

_____

PHYSICIAN'S INFORMATION:

Physician's Name (printed)	**Physician's Signature**	**Date**

Office #: ( ) **Fax#:** ( )

I hereby give permission to The DeKalb Academy of Technology and Environment to administer medication to my child named above as requested by the physician.

		( )	( )
Parent's Signature	**Date**	**Home Phone#**	**Cell Phone #**

DeKalb County School System
Student Health Information

Student's Name: _____

☐Male ☐Female (please circle one) Birth Date: / / Grade _____

School _____ Date: / /

Please check any of the following that applies to the student:

_____ ADD
_____ ADHD
_____ Allergies; Specific type _____
Is EpiPen required? ☐ Yes ☐ No
_____ Asthma
_____ Reactive Airway
_____ Frequent Bronchitis
_____ Chemotherapy/Immunosuppression
_____ Cystic Fibrosis
_____ Depression
_____ Diabetes: ☐Type 1 ☐Type 2
_____ Eating Disorder
_____ Underweight
_____ Overweight
_____ Head Injuries
_____ Hearing Loss
_____ Heart Disease
_____ Hemophilia
_____ Hepatitis
_____ Hypertension
_____ Injury, Major
_____ Kidney Disease
_____ Leukemia
_____ Nosebleeds (frequent)
_____ Organ transplant
(Please circle: Liver/Heart/Kidney)
_____ Orthopedic Problems
_____ Migraine Headaches
_____ Muscular Dystrophy
_____ Pityriasis Rosea
_____ Pneumonia
_____ Psoriasis
_____ Rheumatic Fever
_____ Seizure Disorder
_____ Sickle Cell Anemia
_____ TB
_____ Vision Loss

If the student has any of the above, did he/she receive medical care? ☐ Yes ☐ No

Is the student under medical treatment now? ☐ Yes ☐ No

If yes, what kind of medical treatment? _____

Is the student on any kind of medication? ☐ Yes ☐ No

If yes, please list medication(s) _____

NOTE: **Please see school health personnel for a Doctor/Parent Medication Permission Form.**
A Physician MUST sign a form for EACH medication to be taken in school.

_____ ( )

Parent/Guardian Signature **Phone Number**

THIS INFORMATION IS CONFIDENTIAL AND OPTIONAL. PLEASE RETURN FORM TO CLINIC AT YOUR SCHOOL.

(6b)