

**Clarksville-Montgomery County School System**

**HEALTH SERVICES**

**AUTHORIZATION FOR MEDICATIONS  
TO BE TAKEN DURING SCHOOL HOURS**

The following section is to be completed by the PARENT/GUARDIAN		
School	Child's Name	Date of Birth
Physician's Name, Address and Phone Number		

I request that my child be assisted in taking medication(s) described below at school by legally authorized persons or permitted to medicate herself/himself as also authorized by me and my child's physician. I also give my permission for school personnel to contact my child's physician.

I, \_\_\_\_\_, will assume any and all responsibility and liability for any problems with my child taking this medication at school. I release the CMCSS and its personnel from any legal claims which they have now or thereafter have, arising out of medication taken while at school.

Date	Parent/Guardian Signature	Home Phone	Emergency Phone
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**Medication must be brought to and from school by a parent/guardian or his/her adult designee. Children may not bring medication with them to school or take medication home. (This excludes emergency medications that must remain with the student at all times.)**

The following section is to be completed by the PHYSICIAN for prescription medications or by PARENT/GUARDIAN for Over the Counter medications	
Name of Medication:	
Diagnosis for which medication is given:	
Route:	Dose:
If medication is to be given daily, at what time? (please consider alternative dosing schedule to minimize medication in the school)	
If medication is to be given " <u>when needed</u> " describe indications:	
How soon can it be repeated?	Is child capable of self-carrying medication? Yes ___ No ___ If yes, must complete form HEA-F059.
List significant side effects:	
Length of time this treatment is recommended:	
Other information:	

Date: \_\_\_\_\_  
 \_\_\_\_\_  
 Physician's Signature for prescription medications

**Medication must be brought to school by a parent/guardian or his/her adult designee in a properly labeled (original) prescription bottle with the student's name, pharmacy name & phone number, prescriber's name, date, number of refills, name of medication, dose, & frequency imprinted on label. Over the counter medication must be in the manufacturer's original and unopened container which shows a list of ingredients.**