ACS Athens
American Community Schools

Health Office

## American Community Schools of Athens
## Permission Form for Prescribed and Over-the-Counter Medication

**TO BE COMPLETED BY SCHOOL PERSONNEL**

School: _____ Date form received: _____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization. _____

**Student Name:** _____ Student age: _____ Date of Birth: _____

Grade: _____ Homeroom/Classroom: _____

**TO BE COMPLETED BY PARENT / GUARDIAN**

********** (MUST BE IN CHILD SPECIFIC, CURRENT, ORIGINAL PHARMACY LABELED CONTAINER) **********

**Name of medication:** _____ **Reason for medication:** _____

**ALLERGIES:** _____ **Any OTHER Condition(s):** _____

Form of medication/treatment: _____

Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

**Instructions** (Schedule and dose to be given at school: _____

_____

Start: Date form received Other, as specified: _____

Stop: End of school year Other date/duration: _____

**For episodic/emergency events only**

**Restrictions and/or important side effects:** No restrictions

Yes. Please describe: _____

_____

**Special storage requirements:** None Refrigerate

Other Instructions: _____

**Parent or Guardian Signature** _____ Date: _____

Health Care Provider Name _____

Address: _____ Phone: _____ FAX: _____

I give permission for (name of child) _____ is to receive the above stated medication at school according to standard school policy. I release the School Board and its employees from any claims or liability connected with its reliance on this permission.

**(Parent/guardians to bring the medication in its original container.)**

**Date:** _____ **Signature:** _____ **Relationship:** _____

**Home phone:** _____ **Work phone:** _____ **Emergency or CELL phone:** _____

**ACS Athens Mission Statement:**
ACS Athens is a student-centered international school, embracing American educational philosophy, principles and values. Through excellence in teaching and diverse educational experiences, ACS Athens challenges all students to realize their unique potential: academically, intellectually, socially and ethically — to thrive as responsible global citizens.
**Accredited by: MSA-CESS, IBO, College Board**

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Health Office

**TO BE COMPLETED BY Health Care Provider**

□□□**For Self-Administration or EMERGENCY** □□□**For Self-Administration or EMERGENCY** □□□**For Self-Administration or EMERGENCY**□□□

This student is capable, responsible, and demonstrated self-administration of the above medication:

**Yes - Unsupervised** ☐ **Yes-Supervised** ☐ **No** ☐

This student may carry this medication: **Yes** ☐ **No** ☐ **Any restriction(s):**_____

**The school nurse will delegate and train designated school personnel to give the above stated emergency medication if necessary.**

**Please indicate if you have provided additional information:**

On the back side of this form As an attachment

Signature:_____ Date_____

**Physician or Authorized Provider**

******Over the counter medications can be given no more than 3 consecutive days without written orders from health care provider.**

***Adapted from the Academy of Pediatrics***



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