PLEASE COMPLETE A FORM FOR EACH MEDICATION / MEDICAL PROCEDURE

ATLANTA PUBLIC SCHOOLS
Making A Difference

ATLANTA PUBLIC SCHOOLS

ADMINISTRATION OF MEDICATION / MEDICAL PROCEDURES

Student's Name_____**Homeroom**_____

Date of Birth_____**Telephone#**_____**Emergency #**_____

Address_____

Medication / Medical Procedure_____**Diagnosis**_____

Starting Date of Medication / Medical Procedure_____

Physician's requirements of dosage / method of administration (Please indicate if student is responsible for self-administration and should carry medication / medical equipment _____

_____

Student is capable and recommended to possess, and self-administer this medication / medical procedure:

NO_____**YES-Supervised**_____**YES-Unsupervised**_____

Time medication / medical procedure is to be provided daily_____

Precautions, possible side effects, interventions_____

Drug / Food Allergies_____

Termination date for administering the medication / medical procedure_____

Physician's Name_____

Physician's Address_____

Telephone No._____

Physician's Signature_____ **Date**_____

- *Parent(s) / guardian(s) by signature below acknowledges that the school is providing for the administration of medication / medical procedure as a courtesy to the parent(s) / guardian(s) and agrees to hold the school and school system harmless in its so doing.*
- *Additionally, authorization is granted to obtain pertinent medical and/or copies of records pertaining to my child's medication and for this information to be shared with pertinent staff as needed.*
- *I understand that effective April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPPA"), disclosure of certain medical information is limited. However, I herein authorize disclosure of pertinent medical information for the provision of services for my child while in attendance in the Atlanta Public Schools District. This authorization expires as of the last day of this school year, including the summer/ extended year session.*

Parent(s) / Guardian(s) Signature_____ **Date**_____

Reviewed by:_____ **Date**_____

Principal

_____

School

Distribution: School Clinic – Student's Personal Folder – Parent(s) / Guardian(s) - Health Services