RCSS AUTHORIZATION TO GIVE MEDICATION AT SCHOOL - Pro-Longed Time Period

Student:	d. Please write one medication per page.
	School.
Homeroom leacher:	Grade:
administering of medication to my child a	School, through the principal or designee to supervise/assist in the coording to the instructions below. I understand that:
Medications must be in the origin	al labeled container (no baggies, foil, etc.). Pharmacies can provide a duplicate
or clinic personnel. It will be the responsibility of the	e parent/guardian to inform the school of any changes. New medications or new ew form is completed and a newly labeled container is provided.
 All medications will be taken dire Unused medication will be dispos 	red of unless picked up within one week after medication is discontinued.
	Dose:
Pouts (mouth tonical etc.):	Time(s) to be given:
Terminate medication on:	organism and a second s
Terminate medication on:	Physician Phone:
Condition/Illness requiring medication: _	
Possible side effects, if any:	Fig. Troops, it was the last the second of the control of the cont
What to do in a case of side effect(s):	MICHAGINA SYSTEM
Allergies, Food:	Medication(s):
Signature of health care provider:	Date:
	and a special to assist my child in
I hereby authorize the school personnel, or taking prescribed medication according medication. I understand that, in the even Parent Signature & Date:	ent of a change in medication, I am responsible for completing a new request form.
I hereby authorize the school personnel, taking prescribed medication according medication. I understand that, in the every parent Signature & Date:	employees and officials of the Richmond County School District to assist my child in to district policy and I release them from any liability for administering this ent of a change in medication, I am responsible for completing a new request form. PLAN for SCHOOL-BASED MEDICAID SERVICES
I hereby authorize the school personnel, or taking prescribed medication according medication. I understand that, in the every parent Signature & Date: SERVICE 1. My child is eligible for Medicaid or medicaid	PLAN for SCHOOL-BASED MEDICAID SERVICES T Peach Care YES NO Number Nices YES NO Nursing is in the IEP Other Health Plan
I hereby authorize the school personnel, of taking prescribed medication according medication. I understand that, in the every parent Signature & Date: SERVICE 1. My child is eligible for Medicaid of 2. My child is receiving Special Ed. Service I understand that the school district is able to receive the service of th	PLAN for SCHOOL-BASED MEDICAID SERVICES r Peach Care YESNO Number vices YESNO Nursing is in the IEP Other Health Plan of file with Medicaid or Peach Care for partial reimbursement for the administering of this give my consent for the school district to receive this payment from Medicaid or Peach Care.
I hereby authorize the school personnel, of taking prescribed medication according medication. I understand that, in the every parent Signature & Date: SERVICE 1. My child is eligible for Medicaid of the control of	PLAN for SCHOOL-BASED MEDICAID SERVICES The Peach Care YES NO Nursing is in the IEP Other Health Plan To file with Medicaid or Peach Care for partial reimbursement for the administering of this give my consent for the school district to receive this payment from Medicaid or Peach Care. The responsibility toward the school, which is agreeing to assist me in this matter of the y change/withdraw permission in writing at any time by notifying the Special Education.
I hereby authorize the school personnel, of taking prescribed medication according medication. I understand that, in the every parent Signature & Date: SERVICE 1. My child is eligible for Medicaid of 2. My child is receiving Special Ed. Service I understand that the school district is able to medication or procedure. By signing below, I go I have read this form and understand my medicating/treating my child at school. I mad Director or School Nurse	PLAN for SCHOOL-BASED MEDICAID SERVICES T Peach Care YES NO Number Offices YES NO Nursing is in the IEP Other Health Plan Office with Medicaid or Peach Care for partial reimbursement for the administering of this give my consent for the school district to receive this payment from Medicaid or Peach Care.

Written Authorization for Self-Administration of Asthma

anthorization for self-administration and possession of asthma medication by this student while in school, at a company of a student while in before-school or after-school or after-school. anthorization for self-administration and possession of asthma medication by this student while in school, at a care on school-operated property. The student demonstrates full understanding of the proper use of his/her asthma school-sponsored activity, while under supervision of school personnel, and while in before-school or after-school medication.

The student demonstrates full understanding of the proper use of his/her asthma stand that:

• the school district and its employees and agents shall incur no liability for: a) any injury to the student caused by his or her self-administration of medication except for injury caused by willful or wanton misconduct; b) the * the school district and its employees and agents shall incur no liability for: a) any injury to the student cause his or her self-administration of medication except for injury caused by willful or wanton misconduct; b) the student's use. Overuse, or neglected or failed use of his or her asthma medication; and c) lost, misplace nis or her self-administration of medication except for injury caused by willful or wanton misconduct; b) the outdated, inaccessible, empty, or faulty asthma medication and asthma devices. outdated, inaccessible, empty, or faulty asthma medication and asthma devices.

* the school may choose to require supervision of medication administration in the event that the student does not a proper technique with asthma medication. * the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the possession and/or calf-administration of asthma medication, and that the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the support to require supervision of medication use as deemed appropriate for the safety of all students and student in association with the possession and/or self-administration of asthma medication, and that the school staff. I take sole responsibility for: • the monitoring of asthma medication, medication use, and refilling of prescriptions for asthma medication as the school will not be responsible for the supervising recording and monitoring of self-administered asthma school will not be responsible for the supervising, recording, and monitoring of self-administered asthma • ensuring the student always carries his/her asthma medication on his/her person. • deciding if back-up medication will be kept at the school and providing the school with the back-up medication.
• informing school staff in writing of any changes in the student's treatment or asthma management. • informing school staff in writing of any changes in the student's treatment or asthma management. • informing the school of any asthma exacerbations, hospital visits, and/or new or changed student medical • informing school staff in writing of any medication side effects that warrant communication to the parent/guardian. • coordinating distribution of the student's asthma management and emergency plan to school staff (school health Worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff). I understand and agree to the conditions of the school system policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above-named student. I release the School System and its employees and agents of any legal responsibility related to the above-named student's Parent/Legal Guardian Signature prescription asthma medication and fully understand how and when to use this medication. I will always carry my Date medication with me and will not allow another student to use my medication under any circumstance. I understand and Student's Signature Date The above-named student has been instructed and demonstrates understanding of the proper use of his/her asthma medication. It is my professional opinion that the student be permitted to carry and self-administer his/her asthma medication. I have provided the parent/guardian with a written asthma emergency/management plan including the name, purpose, dosage, and administration directions of the asthma medication.

Healthcare Provider Signature

Written Authorization for Self-Administration of E

Student Name: Property of Student Name:	-Adm:	18/8/9/
Student Name: I, authorization for self-administration and posses and while in before-school or after. I und	ecto- nistrati	of Epipen®, EpipenJr.®
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medication be misused or given or taken by a per School System and its employees and agents of a possession and self-administration of his/her all	ergy medication	to the above-named
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Parent/Legal Guardian Signature		
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,		Date
the above-na prescription allergy medication and fully understant medication with me and will not allow another studies agree to the terms of the school policy.	med student have been instruct d how and when to use this me	•
nedication with me and will not allow	d how and when to use this me	ed in the proper use of my
igree to the terms of the school policy	ent to use my medication under	r any size will always carry my
medication with me and will not allow another stud agree to the terms of the school policy.	thide)	any circumstance. I understand and
Student's Signature	A STATE OF THE PROPERTY OF THE	
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The above-named student has been instructed and onedication. It is my professional opinion that the s	,	
medication. It is my professional opinion that the s medication. I have provided the parent/guardian wi	demonstrates understanding of	the proper use of his/her allers
medication. I have provided the parent/guardian winame, purpose, dosage, and administration direction		