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

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed. Please write one medication per page. Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Homeroom Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School, through the principal or designee to supervise/assist in the administering of medication to my child according to the instructions below. I understand that:

* Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacies can provide a duplicate labeled container with only the school doses.
* Parent/Guardian must provide special instructions, as well as the medication and related equipment, to the principal or clinic personnel.
* It will be the responsibility of the parent/guardian to inform the school of any changes. New medications or new doses will not be given unless a new form is completed and a newly labeled container is provided.
* All medications will be taken directly to the office/clinic by the parent/guardian.
* Unused medication will be disposed of unless picked up within one week after medication is discontinued.

Name of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Route (mouth, topical, etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time(s) to be given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Terminate medication on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician’s PRINTED Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Condition/Illness requiring medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Possible side effects, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What to do in a case of side effect(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies: Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of health care provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SERVICE PLAN for SCHOOL-BASED MEDICAID SERVICES**

1. My child is eligible for Medicaid or PeachCare YES\_\_\_\_ NO\_\_\_\_ Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **My child is receiving Special Ed. Services YES \_\_ NO\_\_ Nursing is in the IEP \_\_\_\_\_\_ Other Health Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby authorize the school personnel, employees and officials of the Richmond County School District to assist my child in taking prescribed medication according to district policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medication, I am responsible for completing a new request form.

I understand that the school district is able to file with Medicaid or PeachCare for partial reimbursement for the administering of this medication or procedure. By signing below, I give my consent for the school district to receive this payment from Medicaid or PeachCare.

I have read this form and understand my responsibility toward the school, which is agreeing to assist me in this matter of medicating/treating my child at school. I may change/withdraw permission in writing at any time by notifying the Special Education Director or the school nurse.

The undersigned authorizes the prescribing physician named above to release any information to the School Board or their designee regarding the medication/treatment to be administered. I, the undersigned, authorize the Richmond County Schools to release pertinent information to the physician.

***Parent- Parent/Guardian Signature & Date***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2025-2026 AH