STUDENT MEDICATION CONSENT FORM AND RELEASE

I certify that I am the parent or legal guardian of the student named herein, and I hereby voluntarily give my consent for

____

(child who is a minor and not yet 18 years of age) to receive the below indicated medication and/or health services from Henry County School District, a political subdivision of the State of Georgia, by and through the Henry County Board of Education (herein "Henry County Schools").

I am voluntarily providing consent with knowledge of the potential and inherent risk of damage and injury involved, and I believe the benefits of this medication and/or health services authorization for my child outweigh the risks. I, for myself and on behalf of my child (if applicable), and each of our respective heirs, executors, personal representatives, next of kin, spouse, and assigns, hereby release the Henry County School District, the Henry County Board of Education, and each of their respective board members, affiliates, directors, leadership, administrators, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with, or in any way related to my participation and/or the participation by my child in the medication and/or health services activities not limited to issues pertaining to the storage and security, as well as administration of the medication that I list below.

Neither the Henry County School District, the Henry County Board of Education, nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible, or in any way accountable for any loss, injury, sickness, death or damage suffered or sustained by any person at any time in connection with or as a result of these medication and/or health services activities, including without limitation any or all loss, injury, sickness, death or damages caused by, or in any way related to, an adverse reaction to the medication(s).

I also understand that I have the right to withdraw this consent at any time upon written notice to the principal's designee at my child's school. I have read and understand the above information in this STUDENT MEDICATION CONSENT FORM and RELEASE, and I give permission for my child's care as described.

I authorize the principal or his/her designee to give medicine to my child according to the label directions from the original pharmaceutical containers, per HCBOE Policy JGCD: Medications (available here) and Regulation JGCD_R(1): Medication Procedures (available here). I authorize the principal or his/her designee to contact my child's physician or pharmacist if additional information regarding medication is needed.

Date: _____________

Parent/Guardian Signature ____

Physician Name: __________________________________ Phone: ____________________________

STUDENT MEDICATION CONSENT FORM AND RELEASE

Student Name: ____

Student Birth Date: ______________Grade: ______ Home Room Teacher: ________________________________

Condition requiring medication: ___________________________________ Prescription: ____yes ____no.

Name of medication (ONE medicine per form): ____

Dosage: ____

Instructions:____

Route (please circle): by mouth; eye (right, left, both); ear (right, left, both); topical; other ____________________

Has your student taken this medication before? ____yes ____no.

When possible, please give the first dose of a new medication at home to observe for potential side effects.

Possible side effects:

____

Is this medication only for use on a field trip? ___yes ___no. If yes, list date and location of field trip requiring this medication.

____

Parent Signature: ____ Date______________

All medications are to be brought to the school by the parent in the original labeled container, marked with the student's name. A new medication form is to be completed for each medication and for any dosage change. When possible, give medicine doses at home before or after school. Medications will be dispensed according to the medication policy JGCD and procedure, JGCD-R (1), of Henry County Schools. Sample medication must be accompanied by a doctor's note indicating the medicine administration directions. ANY unused medication and equipment must be picked up at the end of the school year by the parent. ANY medication not picked by the parent WILL BE DISCARDED. Medicine will NOT be sent home with the student.

Area below to be completed by school staff:

Date	# Doses Received / Staff Initials	Date	# Doses Received / Staff Initials	Date	# Doses Received / Staff Initials

Date picked up FROM school by parent/guardian ________________ # Doses picked up:_______________

Medication Picked up by: __________________________________ ______________________________

Printed Name Signature

Clinic Aide/Staff Initials: _________Clinic Aide/Staff Signature: ____________________________________