SPECIAL NEEDS SCHOOLS OF GWINNETT

MEDICATION FORM

This form **must** accompany any medication sent in for your child to take during school hours. A copy will also be kept on file with your child's current age and weight for use when dispensing "over the counter" medications when necessary and approved by you.

Please make sure that all medication to be given to your child during school is in its **original pharmacy container/prescription bottle**. Also, for the safety of your child and the protection of Special Needs Schools of Gwinnett and its staff, all "over the counter" medications will only be administered to your child in the amount recommended based on size and weight unless otherwise noted by your physician. If, at any time, we find the above requirements in question, any and all medications will be **discontinued immediately** until correct written information is received.

Student's Name: ________________________ Age: _____ Weight: _____

Medication needed:

1. ______________________ reason: __________ dose: _____ time:_____
2. ______________________ reason: __________ dose: _____ time:_____
3. ______________________ reason: __________ dose: _____ time:_____

Comments: ____

I hereby give Special Needs Schools of Gwinnett, Inc. and its staff permission to dispense the above listed medication(s) as requested for the condition(s) stated. I understand that it is my responsibility to maintain current and up-to-date files on any and all medications prescribed and/or dosage changes as prescribed by my child's physician.

Parent signature: ___________________________ Date: ____________________