

EXHIBIT

Descriptive Code: JGCD-E(1)

MEDICINES

Date: 7/20/98

Douglas County School System
Box 1077
Douglasville, Georgia 30133
(770) 651-2000

ASSISTANCE WITH MEDICATION

Child's Name _____ School _____

Address _____ Home Phone _____

Mother's Name _____ Day Phone _____

Father's Name _____ Day Phone _____

Physician's Name _____ Phone _____

Emergency Contact _____ Phone _____

All medication must be placed in an original container. Check with your pharmacist if you need a duplicate bottle. Medication not claimed at the end of the school year will be discarded.

Name of Medication _____

Time to be given _____

Dosage _____

Side effects _____

Termination date for administering medication _____

I hereby authorize the personnel of the Douglas County School District to assist my child in taking medication. I understand that in the event of a change in medication, the parent/guardian is responsible for completing a new request form.

Parent/Guardian Signature Date

Physician's Signature (if possible to obtain) Date

ADOPTED: 3/16/98
REVISED: 7/20/98

Douglas County Board of Education