



**ATLANTA CLASSICAL ACADEMY
ADMINISTRATION OF MEDICATION / MEDICAL PROCEDURES**



PLEASE COMPLETE A FORM FOR *EACH* MEDICATION / MEDICAL PROCEDURE

Reference: APS Policy JGCD - Medication

Form 7

Student's Name _____ **Homeroom** _____

Date of Birth _____ **Telephone#** _____ **Emergency #** _____

Address _____

Drug / Food Allergies _____

Medication Name/ Medical Procedure _____ **Diagnosis** _____

Starting Date : _____ **Termination Date:** _____

Physician's requirements of dosage / method of administration _____

Time medication / medical procedure is to be provided daily _____

Student is capable and recommended to possess, and self-administer this medication / medical procedure:

NO _____ **YES-Supervised** _____ **YES-Unsupervised** _____

Precautions, possible side effects, interventions _____

Physician's Name _____

Physician's Address _____

Telephone No. _____

Physician's Signature _____ **Date** _____

- *Parent(s) / guardian(s) by signature below acknowledges that the school is providing for the administration of medication / medical procedure as a courtesy to the parent(s) / guardian(s) and agrees to hold the school and school system harmless in its so doing.*
- *Additionally, authorization is granted to obtain pertinent medical and/or copies of records pertaining to my child's medication and for this information to be shared with pertinent staff as needed.*
- *I understand that effective April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA"), disclosure of certain medical information is limited. However, I herein authorize disclosure of pertinent medical information for the provision of services for my child while in attendance in the Atlanta Public Schools District. This authorization expires as of the last day of this school year, including the summer/ extended year session.*
- **Our school nurses are governed by the Georgia Nurse Practice Act and APS Policy JGCD – Medication, and they will only administer medication in accordance with written medical orders signed by a licensed physician, dentist, or podiatrist. APS nurses will not modify any dosage of medicine based solely on a request or recommendation by a parent or guardian. A parent or guardian seeking a dosage modification must provide the nurse with an appropriate medical order.*

Parent(s) / Guardian(s) Signature _____ **Date** _____

Reviewed by: _____ **Date** _____

School Nurse

Atlanta Classical Academy
School