STUDENT'S NAME _____ TODAY'S DATE _____

MEDICAL AUTHORIZATION FORM

Permission is granted to the Nurses at the Georgia Academy for the Blind and their designee to supervise my child in taking the following prescribed medication. As the parents/guardian of the above named student at the Georgia Academy for the Blind, I do hereby authorize GAB to act as my representative in giving consent for acute/emergency medical, dental, ophthalmology and/or optometry treatment as well as any psychiatric/psychological counseling necessary, during the school year. In case of an emergency, prior to any major medical treatment, every effort will be made to contact me. As parent/guardian, I will assume responsibility for all expenses involved in the treatment of my child not covered by the school or other insurance. I assume responsibility for expenses incurred related to purchasing prescription medication for my child. GAB will not be financially responsible for providing prescription medication to students. I will provide a valid insurance card to GAB to be used for my student to obtain acute/emergency medical services and/or medication.

I authorize the release of any health care information from any health care facility or physician to the school physician or the school nurse. I authorize the release of any and all health care information from the school physician or the school nurse, which in their best judgment is necessary for the health and well being of my student.

I hereby release and discharge the Department of Education and/or The Georgia Academy for the Blind and its employees and officials from any and all liability in case of accident, injury, damage, or any other mishap in connection with administering and supervising of taking said medication including, but limited to any side effects, illness, or other injury which might occur.

I understand and agree to the following:

- Prescription and over the counter medications provided by me will be in the original container with updated instructions on label.
- The medication form **must** be signed by both parent/guardian and student's attending physician to reduce risk of medication error.
- It is my responsibility to inform the school of any and all changes in student's medication.
- It is my responsibility to provide specific instructions regarding medication or equipment use to Health Services.
- New medication, either prescription or over the counter, will not be given unless a new medication form is completed.
- All medication will be taken directly to Health Services. Students may not keep medication on their person. Exceptions include an inhaler or epi-pen with a physician's written order.

PARENT/GUARDIAN SIGNATURE: _____

STUDENT'S NAME ______________________________________ TODAY'S DATE __________________
DATE OF BIRTH _______________________ ALLERGIES ____________________________________

PLEASE LIST ALL MEDICATIONS, INCLUDING MEDICATION THAT IS TAKEN AT HOME.

MEDICATION ______________________________
STRENGTH ______________AMOUNT GIVEN_____
TIME(S) GIVEN __________________ HOME? Y / N
PLEASE CIRCLE: ORAL / INJECTION / NASAL / OPTIC

MEDICATION ______________________________
STRENGTH ______________AMOUNT GIVEN_____
TIME(S) GIVEN __________________ HOME? Y / N
PLEASE CIRCLE: ORAL / INJECTION / NASAL / OPTIC

MEDICATION ______________________________
STRENGTH ______________AMOUNT GIVEN_____
TIME(S) GIVEN __________________ HOME? Y / N
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MEDICATION ___________________________
STRENGTH __________ AMOUNT GIVEN _____
TIME(S) GIVEN________________HOME? Y / N
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MEDICATION ___________________________
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MEDICATION ___________________________
STRENGTH __________ AMOUNT GIVEN _____
TIME(S) GIVEN________________HOME? Y / N
PLEASE CIRCLE: ORAL/INJECTION/NASAL/OPTIC

PARENT/GUARDIAN SIGNATURE: ____
DATE: __________________PHONE NUMBER (BEST ONE TO REACH YOU) ________________________

PHYSICIANS NAME:________________________________OFFICE NUMBER ______________________
ADDRESS: ____
PHYSICIAN'S SIGNATURE: _________________________________DATE _________________________