CATOOSA COUNTY PUBLIC SCHOOLS
MEDICAL AUTHORIZATION AND RELEASE

Name of Student ____ **Age** ______

Address ____ **Grade** _____

Home Telephone _______________________ **Teacher** _______________________

Father's Name _______________________ **Work #**___________ **Cell #** _________

Mother's Name _______________________ **Work #**___________ **Cell #** _________

If both parents are unavailable, name of person to contact:

____

Name **Relationship** **Telephone #**

MEDICATION MUST BE IN THE ORIGINAL PHARMACY CONTAINER WITH INSTRUCTIONS FROM THE PHYSICIAN!

Please indicate those medications that will need to be taken at school.

Medication Name	Purpose of Medication	Dosage (Amount)	Schedule (When to Use)

SPECIAL INSTRUCTIONS (Ex: For what specific symptoms should we give the medication?):

____

____

____

The undersigned hereby releases and agrees to hold harmless and indemnify the Catoosa County Board of Education and any employee of the Board from any liability whatsoever occasioned by the administration or non-administration of the above described medication to our child during school hours in accordance with the above instructions.

The undersigned authorizes the prescribing physician, ______________________________, to discuss with the principal
(Name of Prescribing Doctor)
and his / her designated staff member any matter regarding the medical conditions and medication administered.

The undersigned also authorizes the school to seek emergency medical treatment for child when necessary and appropriate.

____ ___________________________

Custodial Parent / Guardian Signature **Date**

Revised 5/2012