Bradley County Schools Health Services

Today’s date: __/__/____
Student Name: __________________________________Teacher:_______________Grade:__________

• Medication will be administered during school hours only when their health require it.
• It is the Parent/Guardian responsibility to bring medication to school, in its original container.
• All over-the-counter medications must be clearly marked with the student’s name.
• Prescription medications must include the following information on the label:
  Student Name, RX number, Pharmacy name and phone #, RX date, ordering Physician’s name, medication name, dosage, and route of administration. Medication will only be dispensed as prescribed by the Physician.
• It is the Parent/Guardian responsibility to remove any unused portion of medication when treatment is completed.

Parental Consent for Student Medication Use:
I consent that school personnel assist my student with administration of the following medication during school hours.

Medication Name: ____________________________________Dosage:__________________________
Route of administration: (circle route) by mouth inhalation injection topical (Skin)
Reason medication is to be taken: _______________________________________________________
Time medication is to be taken: Daily at ______ AM/PM or PRN/Every ______ hours as needed
Ending date of medication: ___________ or Medication may be used until: ___________

I declare that my student is able to administer the medication with assistance from staff and I assume full responsibility for any side effects or complications my child may have because of taking this medication.

Parent/Guardian Signature_____________________________________Date______/______/______
Parent Contact phone #______________________________________________________________
Other Emergency Contact #___________________________________________________________

Exceptions:  A = absent      / = weekend     H = holiday/no school scheduled     O= other (list on back)
Name ___________________
Medication: _______________
Dose/Freq: _______________

Nurse Use Only: Medication Count

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<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>+/- RX</th>
<th>NURSE SIGNATURE</th>
<th>PARENT/GUARDIAN SIGNATURE</th>
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Pill counts REQUIRE two signatures. ANY discrepancies are to be reported to the CNM and SRO immediately.