SI:☐ Yes☐ No

Brantley County School Health Services
Authorization To Give DAILY Medication at School
2025 - 2026

Student Name: _____ DOB: ___/___/_____ School: _____

Homeroom Teacher: _____ Grade: _____ Bus #: _____ Car Rider☐

I hereby request the Brantley County School District, through the principal, school nurse, or designee, supervise/assist in the administration of medication to my child according to the instructions contained in the statement below. I understand that:

- All medication MUST be: in its original, most current labeled prescription container and brought to school by the parent/guardian. (Medications brought in baggies or other unmarked containers will not be accepted or administered.)
- It is recommended that a monthly dose supply be provided for routine medications.
- Upon receipt of medication at the school, all controlled prescription medications must be counted by the parent/guardian and the school nurse (or designee) with the amount received properly documented.
- Parents/Guardians must provide: medication, specific instructions, and related equipment needed.
- It is the responsibility of the parent/guardian to inform the school in writing of any changes to medications. If the medication or treatment is changed, a new form must be completed.
- It is the parent/guardian's responsibility to keep up with providing the medication supply in a timely manner, BEFORE the student is out of medication.
- Medications that allow doses to be administered before or after school should not be brought to school for school dosing (**exception:** physician prescribes medications/treatments at a specific time during the school day).

The safety & well-being of your child is our top concern. With your understanding and cooperation, we can decrease unnecessary medication administrations and ensure required medications/treatments are received as directed during the school day. If you have any questions regarding medications, please call the school or your school nurse.

* I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.*

NAME of Medication: _____ DOSAGE: _____

TIME to be given at school: _____ *Dosing as per Rx:* _____

Date Medication will START: _____ Date Medication will END: _____

Physician's Name: _____ Physician's Phone: _____ Fax: _____

Special Instructions: _____

Give dose(s) on: Field Trips☐ Yes☐ No
Early Release Days☐ Yes☐ No
Non-Academic/Celebration Days☐ Yes☐ No

REMIND texting Sign-up:☐ Yes☐ No
*** Text: @bcmsrn25 to 81010**

I have read this form and I understand that school personnel will administer the medication(s) in accordance with the system's procedures. I understand my responsibility to school personnel who are assisting me in this matter of medication administration to my child while at school. I agree that the school system and personnel will not be held legally responsible or liable for any illness or damage that may result from administration or lack of administration of this medication to my child or from the storage of medication supplies for my child. I agree to provide any and all supplies and equipment necessary to carry out this request.

_____ _____ _____/_____/_____

Parent/Legal Guardian Signature **Date** **Home Phone** **Work Phone** **Cell Phone**

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To be completed by the HEALTHCARE PROVIDER for all medications administered at school for greater than 2 weeks:

- **Condition/Illness Requiring Medication: _____ Diagnosis Code: _____**
- **Possible Side Effects of Medication:_____**

_____ _____

Signature of Healthcare Provider **Date**