

BULLOCH COUNTY SCHOOLS
Self-Administration Consent Form for
Non-Prescription (Over-the-Counter) Medication
Middle/High School

(Each medication requires a separate form)

To be completed by the parent/guardian:

Student's Name: _____ DOB: _____ Grade: _____

Over-the-Counter Medication (Name): _____

Dose: _____

Frequency/Times of Self-Administration: _____

School Year: _____

I authorize my child to securely keep/store, and self-administer the over-the-counter medication listed above. I have reviewed the proper method of administration (storage of medication, dosage, date(s), and time(s) to be taken and possible side effects) with my child. I understand the school system does not accept any responsibility for the self-administration of over-the-counter medication, including, but not limited to, the administration, supervision, or documentation thereof.

Students and parents/guardians should be aware that the sale or transfer of any drugs/medications (to include giving away, or making available in any manner) is a violation of the student code of conduct and the severe consequence of zero tolerance will be imposed.

Expiration of Authorization: This authorization shall expire on the last day of school in May.

Parent/Guardian name (please print): _____

Parent/Guardian signature: X _____

Date: _____

Telephone (Home): _____

(Work): _____

(Cell): _____