Bulloch County Schools

Self-Administration Consent Form

Non-Prescription (Over-the-Counter) Medication
for Middle & High School Students

(Each medication requires a separate form)

To be completed by a parent/guardian:

Student's Name:______________________________DOB:____________________Grade: ______

Name of the Over-the-Counter Medication ____

Explain the Proper Dosage of Medication:____

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 consequences of zero tolerance will be imposed.

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

Parent/Guardian name (please print): ____

Parent/Guardian signature:____

Date: ____

Telephone Numbers:

(Home): ____

(Work): ____

(Cell): ____