BULLOCH COUNTY SCHOOLS
Authorization for Medication Administration/ Medical Plan of Care

STUDENT: _____ DOB: _____ Gender: _____

ADDRESS: _____ City _____ GA ZIP: _____

SCHOOL: _____ SS#_____

☐ My child is receiving Special Ed. Services ☐ Nursing is in the IEP ☐ My child has a 504 or Health Plan

PARENT(S)/GUARDIAN(S):_____ PHONE #: _____

As the parent / legal guardian of the student named above I expressly authorize and give permission to Bulloch County Schools to have the designated person administer prescribed medication/treatment to my child. I agree that the school system and its employees shall not be liable or responsible, and shall be indemnified and held harmless for any illness or damage to any person or property which may result from the storage of medication, from giving my child medication/treatment, or from failing to give my child medication/treatment. I accept legal responsibility should the above student lose or give this medication to another person. I understand that if this should happen, my child may be subject to disciplinary action. I have read and understand the Bulloch Countys' medication procedure and the procedure for specialized health procedure/treatment.

My child is eligible for MEDICAID OR PEACHCARE ☐ YES ☐NO Member Number _____

I understand that the school system is able to file with Medicaid or PeachCare for partial reimbursement for the administering of this medication or procedure. I wish the school system to receive this payment from Medicaid or PeachCare.

I have read this form and understand my responsibility toward the school, which is agreeing to assist me in this matter of medicating/treating my child at school. I may change / withdraw permission in writing at any time by notifying the Executive Director of Student Wellness and Support:

Department of Student Wellness and Support
150 Williams Road, Suite A
Statesboro, GA 30458.

Please Return Fax to :_____

The undersigned authorizes the prescribing physician named below to release any information to the School Board or their designee regarding the medication/treatment to be administered. I, the undersigned, authorize Bulloch County Schools to release pertinent information to the physician.

_____ _____
Signature of Parent / Guardian Date

Section 1 Parent/ Guardian please complete ALL items In **Section 1** and return to the school as expeditiously as possible.
The following medication/treatment as listed should be dispensed at school as indicated:

OTC Medication (Name & Dosage):_____

Medication/Treatment:_____

TIME Medication /Treatment is to be given at school: ☐7:30 am - 8:30 am ☐11:00 am - 12:30 pm ☐PRN

TIME Medication /Treatment is given at home:_____

Section 2

Diagnosis: _____

GOAL OF THIS REGIMEN OF MED. /Treat. ☐ Improve Attention Span ☐ Reduce Impulsiveness ☐ Improve School Performance ☐ Control Blood Sugar Level ☐ Control Seizure Activity ☐ Prevent Respiratory Distress ☐ Other please specify:

_____

Rehabilitative Potential: _____

DURATION OF Medication /Treatment: ☐ SCHOOL TERM ☐ Indefinitely

☐OTHER_____

☐ Other information/ medication to note: _____

_____

_____ _____
Physician's Signature DATE

_____ Physician's PHONE _____
Please Print Physician's Name FAX _____

ADDRESS_____

_____

Revised 5/2023