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 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 #_____

May																														
Apr																														
Mar																														
Feb																														
Jan																														
Dec																														
Nov																														
Oct																														
Sept																														
Aug																														
Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3

Initial spaces as administered

Signatures: ( ) _____ ( ) _____

( ) _____ ( ) _____

Exceptions: A = absent / = weekend H = holiday/no school scheduled O= other (list on back)

Name _____
Medicaton:_____
Dose/Freq:_____

Nurse Use Only: Medication Count

DATE	TIME	+/- RX	NURSE SIGNATURE	PARENT /GUARDIAN SIGNATURE	COMMENTS

Pill counts REQUIRE two signatures. ANY discrepancies are to be reported to the CNM and SRO immediately.