Brantley County School Health Services
Authorization To Give OTC/SHORT-TERM Medication at School
2025 - 2026

NOTE: If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed.

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

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

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

- All medication MUST be in its original container, not expired, and be brought to school by the parent or guardian. Medications brought in baggies or other unmarked containers will not be accepted or administered.
- Parents/Guardians must provide: specific instructions, as well as the medication and related equipment needed.
- It is the responsibility of the parent/guardian to inform the school in writing of any changes to medications.
- 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)
- School personnel cannot give medication that contains aspirin to students under 18 years of age due to the correlation with Reye's Syndrome. Examples: Pepto Bismol, Excedrin Migraine, Goody's powder.

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.*

Start Date	End Date	Medication Name	Medication Dosage	Time to be Given	Parent/Guardian Signature	Date

*Student's Pediatrician/Primary Physician: _____ Phone: _____ Fax: _____

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**