Department of Education
Grainger County

P.O. Box 38
7850 Rutledge Pike
Rutledge, Tennessee 37861
Phone 865/828-3611 Fax 865/828-4357
Mark Briscoe, Director

All medication, both prescription and/or over the counter, must be delivered to the principal's office by the student's parent/guardian in the original container. Any alternate means of medication delivery requires prior notification by the student's parent/guardian for the approval of the principal. No more than a month's supply of any medication should be brought to school and **all medication that is not picked up at the end of the school year will be destroyed.** Medication shall be administered only when the student's health requires that it be given during school hours. The pharmacy label must include: Date, Name of student, Prescription number, Name of medication and dosage, administration route and other directions, Licensed prescriber's name and number, Pharmacy name, address, and phone number. Over-the-counter medications must be in original, labeled container.

2023-2024 Student Medication Authorization

Name _____Date of Birth_____ Date_____

Name of Medication:_____ Amount to be taken:_____

How medication is to be taken: (circle) orally opically inhalation injection **Expiration Date: _____**

Time(s) medication is to be taken: _____

Date last dose is to be taken: _____or School Year____2023-2024

Reason for medication administration_____

Signature of Physician (if requested by principal)_____ Date_____

I request that school personnel assist the above named student to self-administer the above medication while at school and away from school for school activities. It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent/guardian. In consideration of the acceptance of the request to perform this service by any person employed by the Grainger County School System, the undersigned parent/guardian hereby agrees to release the Grainger County School System and its personnel from any legal claim they now have or may thereafter have arising out of the administration or failure to administer the above medication to the student. **I WILL ASSUME FULL RESPONSIBILITY FOR ANY SIDE EFFECTS AND/OR COMPLICATIONS THAT MY CHILD MAY HAVE AS A RESULT OF TAKING THIS MEDICATION.**

Parent/Guardian Signature_____ Date_____

Parent/Guardian Name _____ Emergency contact #_____ _____

Comments_____

# of Tablets _____Delivered by _____Received by _____

# of Tablets _____Picked up by _____Witnessed by _____

# of Tablets _____Destroyed by _____Witnesses by _____