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 medications, whether prescription or over-the-counter, must be delivered to the principal's office by the student's parent or guardian in their original containers. If an alternate method of delivery is needed, prior notification and approval from the principal are required. No more than a one-month supply of medication should be brought to school, and any medications not collected by the end of the school year will be disposed of.

Medication will only be administered when necessary for the student's health during school hours. Prescription medication must include a pharmacy label with the following information: date, student's name, prescription number, medication name and dosage, administration route, specific instructions, prescriber's name and contact information, and the pharmacy's name, address, and phone number. Over-the-counter medications must also be in their original labeled packaging.

2024-2025 Student Medication Authorization

Name _____ Date of Birth_____ Date_____

Name of Medication: _____ Amount to be taken: _____

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

Time(s) medication is to be taken: _____

Date last dose is to be taken: _____ or School Year_____2024-2025

Reason for medication administration_____

Signature of Physician (if requested by principal) _____ Date_____

I request that trained school personnel assist the student named above in self-administering the specified medication during school hours and school-related activities. I understand that this assistance is provided solely at my request and as an accommodation. By accepting this service, I, the undersigned parent/guardian, release the Grainger County School System and its trained personnel from any legal claims that may arise from their reasonable and prudent assistance in administering the medication. **I accept full responsibility for any side effects or complications my child may experience as a result of taking this medication.**

Parent/Guardian Signature_____ Date_____

Parent/Guardian Name _____ Emergency contact #_____

Comments_____

Date_____ # of Tablets _____ Delivered by _____ Received by _____

Date_____ # of Tablets _____ Picked up by _____ Witnessed by _____

Date_____ # of Tablets _____ Destroyed by _____ Witnesses by _____