BRIGHTER HORIZONS ACADEMY
COLLEGE PREPARATORY

3145 Medical Plaza Dr., Garland, TX 75044
Tel: 972-675-2062 Fax: 972-675-2063

"Where Knowledge, Faith, Academics and Character Meet."

2024-2025

Students' Name_____ **Drug Allergies**_____ **Grade/Teacher**_____

Parent/Physician Request for Administration of Medications by School Personnel

1. A Medication Administration Permission Form is valid for one year. Medication must be provided by the student's parent/guardian and must be in the original container with dosing instructions (no blister packs, Ziploc bag, or dosing syringe) Medication is NOT provided by the school.
2. Prescription medication must have a pharmacy label stating the child's name, medication, dose and instructions. Pharmacies will provide extra labeled bottle if requested by the parent.
3. Physician signature is **required** for all medication given at school and for self-carry inhalers.
4 .Only medications that cannot be given at home will be given.
6. **Medication that has expired or is not picked up by the parent will be destroyed.**
7. Authorized BHA school personal may administer medication.
8. Expiration date is the responsibility of parent

MEDICATION	Date of Request	Dosage	Time To Give	Days To Give	Is this the initial dose of a new medication not previously administered to your child?
					YES☐ NO☐ Exp. Date _____
					YES☐ NO☐ Exp. Date _____
					YES☐ NO☐ Exp. Date _____
					YES☐ NO☐ Exp. Date _____

Condition for which medication is required: _____

Special Instructions/Precautions/Side Effects of medication on your child: _____

_____

My signature below indicates that it is impossible to schedule the above –mentioned medication at a time other than school hours. I request that Brighter Horizons Academy College Preparatory staff administer the medication specified above to my child, and I am giving permission for Brighter Horizons Academy College Preparatory staff to contact the physician for additional information, if needed.

Parent/Guardian Signature: _____ Date:_____ Parent's Home Phone: _____

Email: _____ Work Phone: _____

Physician's Name: _____ Physician's Phone:_____

*Physician's Signature: _____ Date:_____

(Required)

Medication Count: ***FOR OFFICE USE ONLY!***

Date	# Pills	Counter's Signature	Witness Initials	Date	#Pills	Counter's Signature	Witness Initials

(Indicated by *on back of form):

Date Time	Dose	Admin by (signature)	Comments

STUDENT NAME._____**Grade/Rm**_____

MEDICATION: _____**DOSAGE:**_____**TIME:**_____

DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY
1												1
2												2
3												3
4												4
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30												30
31												31
DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY

A	DC	FT	H	OOM	SF	*
Absent	Discontinued	Field Trip	Hold	Out of Medication	Sent For	Comments

** Indicates comments in front of form*