Bus Driver Medication Form
Hall County Schools

Date: _____ Bus # Assigned To: _____

Name: _____ SSN: _____

Please list below:

- The medications you take
- The dosage of the medication
- How often you take the medication
- Check if it is by prescription or over-the-counter

Medication	Dosage	How Often	Prescribed Yes / No	Over-the-Counter Yes / No

Note to Physician

In your professional opinion, do any of the medications listed above cause adverse reactions that could interfere with the safety of driving a school bus? Yes ☐ No ☐

Additional Notes or Comments

_____

_____

_____ _____

Physician's Signature Date

If signed by PA or NP, complete the following: _____

Print Name of Supervising / Delegating Physician

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