SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name _____

School_____Grade_____Teacher_____ School Year_____

List any known drug allergies/reactions_____Height (inches) _____Weight (lbs)___

PRESCRIBER AUTHORIZATION

Name of Medication _____Reason for Taking _____

Dosage _____ Route _____Frequency/Time(s) to Be Given_____

Begin Medication_____ Stop Medication _____
Date Date

Special Instructions:

Does medication require refrigeration? Yes ☐ No ☐

Is the medication a controlled substance? Yes ☐ No ☐

Is self-medication permitted and recommended for this student? Yes ☐ No ☐

If asthma inhaler or emergency medication, do you recommend this medication be kept **"on person"** by the student? Yes ☐ No ☐

Potential Side Effects/Contraindications/Adverse Reactions

_____

_____

_____

_____

Treatment Order in the event of an adverse reaction: (Attach additional sheet or use the back of this form if necessary)

_____

_____

_____ _____ _____ _____

Signature of Prescriber **Date** **Phone** **Fax**

PARENT AUTHORIZATION

I authorize the School Principal or his designee to assign unlicensed school personnel who has completed the Mississippi Board of Nursing *Assisted Self Administration Curriculum* the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered by the school nurse. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate.

Date _____ **Signature of Parent or Guardian**_____ Phone # _____

OR

DO NOT SIGN IN BOTH BOXES

Before any medication is administered to my child by non nursing personnel, I request that I _____be called to come to the school to administer the above medications to my child.

Date _____ **Signature of Parent or Guardian** _____

If any questions or problems arise, call me at: (H)_____(W)_____(Cell)_____