CCSD MEDICATION ADMINISTRATION AUTHORIZATION FORM

This form must be completed fully in order for schools to administer the required medication. A NEW MEDICATION ADMINISTRATION FORM MUST BE COMPLETED AT THE BEGINNING OF EACH SCHOOL YEAR, FOR EACH MEDICATION, AND EACH TIME THERE IS A CHANGE IN DOSAGE OR TIME OF ADMINISTRATION OF MEDICATION.

Prescriber's Authorization

Name of Student:_____ Date of Birth: _____ Grade: _____

Condition for which medication is being prescribed: _____

Medication Name:_____ Dose:_____ Route:_____

Time/frequency of administration:_____ If PRN, frequency:_____

If PRN, for what symptoms:_____

Side effects:_____

Prescriber's Name/Titie:_____ Telephone #:_____ Fax #:_____

Prescriber's Signature:_____ Date:_____

Parent/Guardian Authorization

I give permission for the school nurse or delegate to administer the above medication to my child. I give my consent for the Choctaw County School District to contact my child's physician regarding administration and effectiveness of prescribed medication. I agree to release the Choctaw County School District and its employees who are acting within the scope of their duties from any liability or compensation in any and all claims arising from the administration of medication at school to my child. I agree to the following responsibilities regarding medication administration:

1. The first dose of a newly prescribed medication should be given at home.
2. Prescription medication must be in a container labeled by the pharmacist.
3. Non-prescription medication must be in the original container with the label intact.
4. Any medication to be given at school must be brought in by the parent or guardian. Do not send any medication to school with your child.
5. At the end of the school year, the parent or guardian must pick up medication from the school.

Parent Signature:_____ Date:_____

Home Phone #:_____ Cell Phone #:_____ Work Phone #:_____

School Nurse Signature:_____ Date:_____