

**PRESCRIPTION MEDICATION
PHYSICIAN'S ORDER AND PARENTAL CONSENT**

The medication administration policy of the McNairy County School System requires that medications be administered only when the student's health requires that they be given during school hours. Medications administered at school must be in the original container with pharmacy label attached and administered under the supervision of the school nurse, school principal or his/her designee. Written authorization from the student's parent/guardian and prescribing doctor is required, and is for the current school year only.

STUDENT'S NAME _____ School: _____

PHYSICIAN'S SECTION

The above named student is to receive: (Give medication name, dosage, route, and specific time that medication is to be administered at school.)

This medication is for the treatment of: (Diagnosis) _____

Date of the termination of this medication: _____

Possible side effects and other special instructions: _____

Date: _____ PHYSICIAN SIGNATURE: _____

Physician Name: _____

Physician Address: _____

(PLEASE PRINT) _____

Phone Number: _____

PARENT/GUARDIAN CONSENT SECTION

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent/guardian. The undersigned understands that the student will self-administer the medication with assistance from trained school staff and declares that the student is competent to take his/her own medication. The undersigned assumes full responsibility for any side effects or complications his/her child may have as a result of taking this medication, and is responsible for informing school staff of any changes in treatment. New physician's orders must accompany any change of physician or change in medication dosage. I understand that I can withdraw my permission by telling school staff and removing the medicine from the premises. I understand that any medicine that I do not pick up by the last day of school will be disposed of. I am the legal guardian and hereby give my permission for my child to take the above medication.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Parent/Guardian Name (Please print): _____ Home Phone _____

Address: _____

Workplace and Phone: _____ Emergency Phone: _____