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:_____

(PLEASE PRINT)

Physician Name: _____
Physician Address: _____
_____
_____
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:_____