PRESCRIPTION MEDICATION
AUTHORIZATION FORM

This form is to be completed and signed by the parent/guardian and the physicain authorizing medication to be given to the student during school hours. This form must be completed for prescription medications and returned to the school before the medicine can be given. All medication must be in a current pharmacy-labeled container with the child's name on it. If any changes occur during the school year, a new form must be completed and returned to school. The first dose of medication should always be given at home in case of an adverse reaction.
Please use a separate form for each medicine. This form is good for one school year.

Parent Permission Section (to be completed by parent/guardian)

Student _____ DOB _____ Gender _____

Teacher _____ Grade _____ School _____

Parent/Guardian _____ Phone _____

Emergency Contact _____ Phone _____

Physician's Name _____ Phone _____

____ My child is capable of and has been instructed in the proper method of self-administration of this medication. I understand that if my child misuses or exceeds the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication and will call me immediately.
____ My child requires assistance in the administration of this medication.
____ My child is capable of and has been instructed in the proper method of self-administration of his/her diabetic or asthma medication. I understand that my child shall be permitted to carry at all times his/her medication, as long as he/she does not endanger him/herself or other persons and will not misuse the medication.

I understand that the Department of Education, its employees or agents shall not incur any liability as a result of any injury arising from the self-administration of the medication by my child, shall exempt from liability and hold harmless school employees or agents against any claims arising out of the self-administration of medication by my child, and I understand that this authorization shall be effective for this current school year and must be renewed annually.
We are required by law to maintain the privacy of your medical records. This privacy practice is adopted to ensure that the staff at Maryville City Schools protects your privacy. We consider it our duty to prevent unlawful disclosure of your medical records. Except as otherwise permitted or required by law, we will not use or disclose your health records without your written authorization.

Parent/Guardian Signature _____ Date _____

Provider Authorization Section (to be completed by provider)

Diagnosis for which the medication is needed: _____

Medication (one per form) _____ Dose _____

Route _____ Frequency _____ Allergies _____

If given as needed, describe/list indicators: _____

_____

Possible side effects _____

Physician's Signature _____ Date _____