



## PRESCRIPTION MEDICATION AUTHORIZATION FORM

This form is to be completed and signed by the parent/guardian and the physician 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.

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.

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, hereby, on behalf of myself, my child, and my child's other parent and legal guardian(s), assume all risk of harm and injury relating to or arising from prescription medication given to my child at school or in school related activities pursuant to this authorization. I hereby agree to indemnify and hold harmless the Maryville Board of Education, its employees and agents, ("Indemnified Parties") from any and all claims, causes of action, damages or liabilities ("Claims") arising from or relating to the self-administration of medication by my child at school, including but not limited to, reasonable attorney's fees and costs incurred by the Indemnified Parties in defense of any Claims. I understand that this authorization shall be renewed annually.

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 \_\_\_\_\_