Rankin County School District
TRADITION OF EXCELLENCE

CONSENT FOR MEDICATIONS AT SCHOOL

PARENT AUTHORIZATION-INDEMNITY AGREEMENT AND PHYSICIAN ORDER FOR ADMINISTRATION OF PRESCRIPTION OR OVER THE COUNTER MEDICATION(S) AT SCHOOL

STUDENT INFORMATION (To be completed by the parent):

First Name: _____ Middle: _____ Last: _____

School: _____ Grade: _____ Homeroom Teacher: _____

Height: _____ Weight: _____ Date of Birth: _____ Age: _____

Parent(s)/Guardian(s) Emergency Contact Numbers:

Name: _____ Home #: _____ Cell: _____ Work: _____

Other: _____ Relation: _____

The undersigned parent(s) or guardian(s) of the student named above, a minor child, have requested personnel of the Rankin County School District or Region 8 Mental Health Services and their nurses , employees, directors, agents and volunteers to administer prescription and/or Over the Counter (OTC) medication to this student. This request has been made for my/our convenience as a substitute for parental administration of this medicine. If there is not a licensed and registered school based nurse available to administer medications at the school, it is understood that the school principal or his/her designee will assign unlicensed school personnel or employee/volunteer that does not have medical or nursing training but has completed the Mississippi Board of Nursing "Assisted Self Administration Curriculum" the task of assisting the child in taking the medication. I/We understand that additional parent/prescriber signed statements will be necessary if the medication or dosage of medication is changed. I/We also authorize the School based Nurse or employee to talk with the prescriber or pharmacist should a question come up about the medication. I/We understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, pharmacy, pharmacy number, date of prescription, name of medication, dosage, strength, time interval, rout of administration, and the date of drug's expiration when appropriate. If the medication is over the counter (non-prescription), then it must be registered with the school in the original container and the child's name must be written legibly on the bottle. All medication(s) must be registered by the principal or his/her assigned designee and approved by the school based nurse prior to administration of medication at school. I/We forever release, discharge and covenant to hold harmless the Rankin County School District, its personnel, its employees, agents, volunteers or nurses and Board of Trustees or Region 8 Mental Health Services and it's nurses , employees, directors, agents and volunteers from any and all claims, demands, damages, expenses, loss of services and causes of action belonging to the minor child or to the undersigned arising out of or on account of any injury, sickness, disability, loss or damages of any kind resulting from the administration of the prescription medicine. The undersigned agree to repay the school district or Region 8, its personnel or Trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or on account of any such injury to the minor child as a result of the administration of medicine. I have read the foregoing release and indemnity agreement and fully understand it. Executed this the _____ day of, 20__.

_____	_____	_____
Parent or Guardian Signature	Name Printed	Witness

PRESCRIBER AUTHORIZATION (To be completed by a Physician or Licensed Practitioner)

Name of Medication (one per form}: _____ Check Prescription ❍ or OTC ❍

Condition for which medication is needed (diagnosis): _____

Dosage: _____ Route: _____ Time(s)/Frequency to be given: _____

If PRN, list Frequency: _____

AND specific symptoms when to administer: _____
(I.E. HEAD OR STOMACH ACHE, WHEEZING OR OTHER SYMPTOMS EXHIBITED WITH THE MEDICAL CONDITION

If the medication is an asthma inhaler or epinephrine / epi-pen, this student is authorized for self carry and has been instructed on and demonstrated the proper technique in administering the medication? Yes ❍ No ❍

_____	_____	_____
Prescriber Name & Title (Print)	Prescriber Signature (or signature stamp)	Date

Physician Phone #: _____ Fax #: _____

Updated 7/31/2019