

### Tupelo Public School District Authorization to Administer Medication / Procedure Consent Form

All prescription medication dispensed at school, including students who carry and self-administer inhalers / epi-pens must have written instructions signed by the practitioner and the parent/guardian.

**Parent/Guardian Name:** \_\_\_\_\_ **Daytime phone:** \_\_\_\_\_

I/We, the parent(s)/guardian(s) of \_\_\_\_\_; \_\_\_\_\_  
*Student's Name* *Date of Birth*

- give consent for school personnel to administer the following medications according to the directions stated by the named licensed provider below;
- consent to the free exchange of information regarding this medication between the licensed prescriber/physician and school personnel;
- agree to notify the school in writing of any changes or termination of this request;
- understand that the medication must be delivered to the school in the original over-the-counter or prescription package detailing instructions for medication administration including student name, drug dosage, time/frequency to be administered and physician/licensed prescriber name;
- understand that any unused medication must be picked up at school by me/us in the school office;
- understand any medication not picked up by the last day of school will be disposed of by school personnel;
- agree to hold school personnel harmless in any and all claims arising from the administration of this medication at school or school related events;
- understand that this medication order is in effect for the current school year and potential summer school year only.

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**DAILY MEDICATIONS**

Medicine Name      Route      Dose      Frequency/Time      Direct contact with the physician shall be made for the following reasons:


**PRN (as needed) MEDICATIONS**

Medicine Name      Route      Dose      Frequency/Time      Condition under which medication should be given:


According to school policy, no prescription medication will be administered to a student without written medication orders from parent and physician. These orders must include the name of the drug, dosage, frequency/time to be administered, length of time medication is to be administered, reason medication is prescribed and conditions under which contact with the physician should be made.

I am prescribing medication for the above named student who has a diagnosis of: \_\_\_\_\_

Prescriber/Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Office/Clinic Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Licensed Prescriber / Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPROVAL FOR STUDENT CARRYING AN INHALER and/or EPI-PEN**

This student has received instruction and has demonstrated competency in the use of a metered dose inhaler / Epi-Pen (circle). He/She may carry and self-administer as prescribed. \_\_\_\_ YES \_\_\_\_ NO

Licensed Prescriber / Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_