

Fayetteville City School System

RAS FMS FHS

Fayetteville, Tennessee 37334

**PRESCRIPTION MEDICATION PERMISSION FORM
TO BE FILLED OUT BY HEALTHCARE PROVIDER OFFICE**

School (Circle): RAS FMS FHS

Student: _____ Date: _____

Physician: Is it NECESSARY that medication MUST be self-administered DURING SCHOOL HOURS?
Please Circle Y N

If Inhaler: Do you authorize self-possession of inhaler while at school? Y N NA

Fayetteville City School System may suspend or revoke the student’s possession and self-administration privileges, if student misuses inhaler or makes inhaler available for usage by another student.

Medical Condition: _____

Medication: _____

Dosage: _____

When Give? _____ Do not exceed _____ doses at school.

How Often? _____ Duration? _____

Possible Side Effects of Med: _____

Physician: _____

Printed Name

Physician Signature

Healthcare Office Stamp:

It is solely understood that assistance in self-administration is given to the student solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of acceptance of the request to perform this service by any person employed by the Fayetteville City School System, the undersigned parent/guardian hereby agrees to release the Fayetteville City School System and its personnel from legal claim, which they now have or may thereafter have arising out of any employee’s assistance in a student’s self-administration of medication. I, hereby, authorize for my child to self-administer the medication above listed while at school.

Date: _____ Parent/Guardian Sign: _____

MEDICATION MUST BE IN ORIGINAL PHARMACY LABELED CONTAINER.