KOSCIUSKO SCHOOL DISTRICT

KOSCIUSKO, MS 39090

SCHOOL MEDICATION PHYSICIAN AUTHORIZATION

PARENT AUTHORIZATION/INDEMNITY FORM

Student Name: _____ School Year:_____
School: _____ Grade: _____ Homeroom Teacher: _____

PRESCRIBER AUTHORIZATION

List any known drug allergies/reactions:

_____

Height _____ Weight _____
Name of Medication: _____
Reason for Taking: _____
Dosage: _____ Route: _____
Frequency/Time(s) to be given: _____
Begin Medication Date: _____ Stop Medication Date: _____

Special Instructions: **_____**

_____

Does medication require refrigeration? Yes or No
Is the medication a controlled substance? Yes or No
Is self-medication permitted and recommended for this student? Yes or No
If asthma inhaler or other emergency medication, do you recommend this medication be kept "on person" by the student? Yes or No
Potential Side Effects/Contraindications/Adverse Reactions:

_____

_____

Treatment Order in the event of an adverse reaction (Attach Action Plan for Asthma, Diabetes, Severe Allergies, Seizures, or Other Serious Condition)

_____

_____

_____

Signature of Prescriber: _____ Date: _____
Phone: _____ Fax: _____

Parent signature on the back of this form gives permission for the school nurse to speak with prescriber and/or pharmacy regarding this medication.

PARENT AUTHORIZATION MUST ON THE BACK OF THIS FORM MUST BE COMPLETED BEFORE ADMINISTRATION OF MEDICATION

PARENT AUTHORIZATION/INDEMNITY

I authorize the School Principal or his designee to assign unlicensed school personnel who have completed the Mississippi Board of Nursing Assisted Self Administration Curriculum the task of assisting my child in taking the medication listed on the reverse side of this form. I understand that school personnel administering this medication may not have to have any medical or nursing training. I understand that this request has been made for my convenience as a substitute for parental/guardian administration of the named medicine.

I forever release, discharge and covenant to hold harmless the Kosciusko School District, its personnel, and its Board of Trustees from any and all claims, damages, expenses, loss of services and causes of action belonging to the minor child listed or to the undersigned arising out of or on account of an injury, sickness, disability, loss or damages of any kind resulting from the administration of this medication.

The parent/guardian agrees to repay the Kosciusko School District, its personnel or Trustees any sum of money, expenses, or attorney's fee 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 listed as a result of the administration of named medication.

I release the Kosciusko School District, its personnel, and Trustees from any liability for injury arising from my child's self-administration of any medication while on school property or at a school-related event or activity. I understand that additional physician/parent signed statements will be necessary if any medication changes occur. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question arise about the medication. Medication must be registered by the school nurse or designated school personnel. A medication administration log will be maintained by school personnel for each medication. Medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, route, administration time/interval, and discontinue use date and expiration date when appropriate.

Student's Name: _____ Name of Medication: _____

Parent/Guardian PRINTED Name: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Witness: _____

Date	Medication Name/Strength	# Received	# Returned	Parent Signature	Staff Signature