DEPARTMENT OF SCHOOL NURSING SERVICES
800 M.S. Couts Blvd., Suite #1
Springfield, TN 37172
Phone: 615-382-3606 Fax: 615-382-2306

Student_____ **DOB**_____

School_____ **Grade**_____ **Teacher**_____

The medication administration policy of the Robertson County School System states, "Medications shall be administered only when the student's health requires that they be given during school hours." A responsible adult must bring medications to school. Prescription medication must have a proper pharmacy label attached. Non-prescription medications must be in a new unopened container. Medications shall be kept in a secure area of the clinic. Emergency medications may be kept with students if noted by the physician.

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER
(If non-prescription medication, parent must complete)

Name of Medication_____**Scheduled Time**_____
Dosage, Frequency, and Route_____
Form of medication/Treatment: ☐ Tablet/Capsule ☐ Liquid ☐ Injection ☐ G-tube ☐ Inhaler ☐ Nebulizer ☐ Other_____
Reason for medication_____
Restrictions &/or important side effects: ☐ None anticipated ☐ YES (describe):_____
_____
Special Storage Requirements: ☐ None ☐ Refrigerate ☐ Other_____

School Clinic Use Only: Date Received_____
Medication to be given till: ☐ End of School Year ☐ Other Date/Duration_____
Is this student both capable and responsible for assisted self-administering this medication?
☐ YES, supervised (trained employee may assist) ☐ NO, a nurse must administer.

For episodic/emergency use only: ☐ YES ☐ NO
Emergency Medications Only: ☐ Student is both responsible and capable of carrying and self-administering this med in the event of emergency.
Physician Signature_____ Date_____

Physician's Name_____Phone #_____Fax#_____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child to receive the above medication during the school day assisted by school personnel as necessary.
*My child is both capable and responsible to self-administer this medication (with assistance), or if carrying an emergency medication, is capable and responsible without assistance. ☐ YES ☐ NO

Parent Signature_____ Date_____

Phone Numbers in case of emergency_____

*****Only completed forms will be honored. Written authorization is for current school year only.*****