Rankin County School District
TRADITION OF EXCELLENCE

CONSENT FOR MEDICATIONS AT SCHOOL

School

STUDENT INFORMATION (TO BE COMPLETED BY THE PARENT):

Name Date of Birth Age
Homeroom Teacher Grade
Height Weight Allergies

PARENT(S)/GUARDIAN(S) EMERGENCY CONTACT NUMBERS:

Name Relation
Cell Other Number

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 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 who does not have medical or nursing training but has completed the MDE required training 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 arise 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 the medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate. If the medication is over the counter, 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 assigned designee before administration of medication at school. I/We understand that medications used in case of an emergency are stored in a specific location inside the school and will only be given when the student is on the school campus, excluding the bus to and from school unless the student has been permitted by the provider to self-carry emergency medication. 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 its 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 agrees 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. Agreed and consented to on _____ *day of* _____ *the year* _____.

Mother/Father/Guardian Printed Name | Mother/Father/Guardian Signature

PRESCRIBER AUTHORIZATION (TO BE COMPLETED BY A PHYSICIAN OR LICENSED PRACTITIONER)

Name of Medication (one per form)
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
If the medication is prescribed for emergencies, is this student authorized for self-carry and been instructed on and demonstrated the proper medication technique? Yes ☐ No ☐
Health Care Provider Phone #

Health Care Provider Name & Title (Print) | Health Care Provider Signature | Date