

## MURFREESBORO CITY SCHOOLS MEDICATION ADMINISTRATION FORM

Requests for a student to self-administer his/her own medication during school hours require that this statement be filed with the school nurse or the school principal. Consideration of this request will be based on school health guidelines. Please respond to every item on this form. Only fully completed forms will be honored. If non-prescription, physician signature is also required (see below).

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Diagnosis/Reason for medication: \_\_\_\_\_ Drug/Food Allergies: \_\_\_\_\_

### HEALTH CARE PROVIDER STATEMENT

The health care provider must be a licensed prescriber (MD, DO, PA, NP, etc.) If non-prescription medication, parents may fill out this portion. A physician's signature is required to give **ANY** medication to your child during school hours. A new form is required for each school year, or as needed for changes in medication order.

Name of Drug/Purpose: \_\_\_\_\_

Dosage, Route: \_\_\_\_\_

Times to be administered at school: \_\_\_\_\_

Date to Start: \_\_\_\_\_ End Date (if other than end of school year): \_\_\_\_\_

**Does this medication absolutely need to be administered during school hours?** ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

Special instructions for storage/handling: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

If the dose of this medication is different from the manufacturer's recommended dose range for the age or weight, please include your rationale for prescribing outside these recommendations: \_\_\_\_\_

Health Care Provider Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### STUDENT AND PARENT STATEMENTS

I give consent for my child, \_\_\_\_\_ to take his/her own medication during school hours assisted by school personnel, if necessary. My child is competent to self-administer medication with assistance ☐ Yes ☐ No

**My child has a serious health condition and needs this medication with him/her at all times.**

☐ Asthma ☐ Allergy ☐ Diabetes ☐ Seizure ☐ Other: \_\_\_\_\_

#### By signing below, I acknowledge and agree to the following:

I understand that Murfreesboro City Schools (MCS) and its designated employees shall not be held liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, in accordance with T.C.A. § 49-50-1602. I take full responsibility for ensuring that any medication—both prescribed and non-prescribed—is provided in its original pharmacy-labeled container and delivered to the school by a parent or guardian. I understand that students are not permitted to carry medication unless authorized by school policy. I give consent to Murfreesboro City Schools nurses to communicate with my child's healthcare provider regarding medications, diagnoses, and any matters necessary to ensure the safe and effective delivery of health services during the school day. I also authorize the electronic exchange of relevant health information necessary for the coordination and provision of care for my child throughout the school year. I understand that all health information shared or obtained will be kept confidential and protected in accordance with applicable privacy laws and regulations.

PRINTED Parent/Guardian Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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