School: _____ School Year: _____

MURFREESBORO CITY SCHOOLS
MEDICATION ADMINISTRATION FORM

Requests for a student to self-administer his/her own medication during school hours will be filed with the school nurse or the school principal. Please respond to every item on this form. If non-prescription, physician signature is also required (see below).

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

Teacher:_____

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, parent may fill out this portion. A physician's signature is required to give ***ANY*** medications to your child during school hours. You, the parent or guardian will provide all medication. Students will receive no more than three doses of OTC medication without a physician's signature.

Name of medication: _____

Dose:_____

Time to start: _____

Times to be administered at school: _____

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: _____

Health Care Provider Name: _____ Phone: _____

Address: _____

Health Care Provider Signature: _____ Date: _____

STUDENT AND PARENT STATEMENTS

I take full responsibility for taking my own medication during school hours as prescribed by my health care provider and authorized by my parent or guardian. Both prescribed and no-prescribed medications must be in the original container when brought to the school by the parent or guardian and given to a school official.

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**

I have read the Medication Administration Form ☐**Yes** ☐**No**

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

☐ **Asthma** ☐**Allergy** ☐ **Seizure** ☐**Other** _____

My signature below provides consent for Murfreesboro City School Nurses to communicate with my child's health care provider regarding medication, diagnosis and any issue related to the safe delivery of health services during the school day. My signature also gives consent for electronic exchange of health information relevant to health care and delivery of services provided for my child during the school year. My signature also indicates that I understand that any information obtained is confidential and protected.

Parent/Guardian Signature: _____ Date: _____

Phone Number (in case of emergency): _____ Date: _____

It is the parent's responsibility to update the nurse/Health Services when phone numbers change.

Alternative Contact person and phone number:

Name: _____ Phone: _____