MEDICATION ADMINISTRATION REQUEST AND CONSENT FORM

TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name (Last, First, Middle) Date of Birth Grade/Teacher

Parent/Guardian Address

Home Phone Work Phone Other (cell)

TO BE COMPLETED BY PHYSICIAN

Medication _____ Reason for Medication*_____

Start Date: _____ Stop Date: _____

_____Tablet/capsule _____Liquid _____Inhaler _____Injection _____Nebulizer _____Other_____

Dosage Amount: _____ Time(s) to be administered at School _____

If administered as needed, how often can dosage be repeated? _____

Restrictions: _____

Side Effects: _____

Special Storage Requirements: _____

Mississippi Law (MS CODE, 1972 as amended, Sec. 41-79-31) allows students to process and self-administer asthma or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/guardian, student's physician, and waiver of liability by the parent/guardian; all students with an asthma diagnosis are required by said law to have a current Asthma Action Plan on file. ***("Self-carry" option is not recommended at elementary school level.)***

This student has been instructed on self-possession and self-administration of this medication, and is both capable and responsible:
_____Yes _____No _____Supervision required _____Supervision not required

This student may self-carry his/her medication: _____Yes* _____No Physician's Initials _____
(*Requires completion of Student Agreement Contract)

Print Physician's name Physician Address Phone

Physician's Signature Date

TO BE COMPLETED BY PARENT/GUARDIAN
(This form is void if not completed)

I request the designated school personnel or its agents to assist my child in the administration of the above prescribed medication. I give permission to my child to take this medication while in school or participating in school activities away from the school site. I understand that (1) there is no liability on the part of the school district, its personnel or agents, including the nursing staff of the **Sunflower County Consolidated School District**, for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as a reasonably prudent person would have acted under the same similar circumstances; (2) this medication must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if not picked up within one week following the above stop date, or one week after the close of the current school year, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel.

Parent/Guardian Date

TO BE COMPLETED BY PERSONNEL

School _____School Year _____ Date Form Received _____

I/We acknowledge receipt of this Mediation Authorization_____