Pearl Public School District
Parent Medication/Treatment Request

Student: _____ Date of Birth: _____

Teacher/Grade: _____

I request that medication/treatment be administered to my child in accordance with the instructions of his/her health care provider. I agree to provide a medication/treatment authorization form from his/her health care provider. I understand that my child will self-administer medications with assistance of designated school personnel according to protocol outlined by the Mississippi Board of Nursing. Inhalers or epi-pens carried by the student and medication patches worn to school also require medication authorization forms.

I understand that the medication is to be delivered to the school by a parent/guardian in an original container labeled with the student's name, medication and dosage. **The label must match the medication order and must be current**. The student will not be allowed to transport medication to or from school. Only inhalers and/or epi-pens may be transported by students when proper medical authorization is provided. I agree to notify the school in writing immediately if there is a health care provider change, change in treatment, medication or dosage is changed, or medication or treatment is discontinued. Unused or discontinued medication should be picked up by the parent/guardian or it will be disposed of by nursing personnel. I understand that I will provide any supplies needed for treatments for my child.

The student may possess and use asthma medications and/or anaphylactic medications at school or school sponsored activities when specifically ordered by their health care provider. The health care provider must provide a statement that the student has asthma and/or anaphylactic reactions and has been instructed in self-administration of asthma medications and/or anaphylactic medications. The school and its employees shall incur no liability as a result of any injury sustained by the student as a result from self-administration of asthma medications and/or anaphylactic medications.

I release the Pearl Public School District and school personnel of any liability and accept full responsibility for harm that may result from my child receiving medication during school. I understand that if these terms are not met, the school has grounds for refusal to administer medications.

Physician's Name_____ Telephone_____

I give my permission for the school nurse to talk with the health care provider as needed concerning my child's care/medication when at school. I understand that health information will be kept confidential and only shared with teachers on a "need to know" basis.

_____ _____

Parent/Guardian Signature Date

_____ _____

Home Phone Emergency Phone

Pearl Public School District
Physician Medication/Treatment Authorization
(for medication/treatments required during school hours-inhalers, epi-pens and medication patches also require orders)

To be completed by student's PHYSICIAN

Student Name: _____ DOB: _____

Diagnosis for which medication is given: _____

Name of Medication: _____

Concentration/Dose: _____

Time: _____ Frequency: _____

Duration of treatment: _____

Significant side effects: _____

If applicable, has student been instructed in self-administration of asthma medication & knows the name, dosage, time & proper technique? Yes _____ No _____

If applicable, has the student been instructed in self-administration of epinephrine for anaphylactic reactions and knows name, dose, indication for use, and device and method of administration?
Yes _____ No _____

If applicable, the student applies the medication patch, _____, at home each day. It is given for _____. He/she needs to wear this during school hours.

Additional Information _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Printed Name Phone Number

May fax to Nurse at:
_____Lower Elementary 601-932-7978
_____Northside Elementar601-932-7984
_____Upper Elementary 601-932-7983
_____Junior High 601-420-2394
_____High School 601-932-7992