REQUEST FOR: ASSISTED SELF-ADMINISTRATION OF MEDICATIONS PRESCRIPTION and NON-PRESCRIPTION MEDICATIONS

Requests for a student to administer medication during school hours requires that this statement be filed with the school principal. Consideration of this request will be based on school health guidelines. Please respond to every item on this form. Only totally completed forms will be honored.

School _____ **School Hours** _____ **Teacher** _____ **Grade** ____

Student Name _____ **Date of Birth** _____ / _____ / _____
Last First Middle

Address _____ **Telephone** _____

Medical Conditions (Optional) _____ **Cell Phone** _____

HEALTH CARE PROVIDER STATEMENT

The health care provider may be a medical doctor (MD, DO), dentist (DDS), physician assistant (PA), or an advanced nurse practitioner (APRN/NP). To be completed by health care provider. A new form is required each school year. If non-prescription medication, parent must fill out this form

Name of Drug / Purpose of Drug : _____

Date to Start: _____ **through** _____

Dosage, Route and Times at School _____

Does this medication absolutely need to be administered during school hours? _____**Yes** _____**No** **If yes, explain:** _____

_____

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 of these recommendations _____

Special instructions for storage and handling: _____

Possible side effects: _____

Health Care Provider Name: _____ **Phone:** _____

Address: _____

Health Care Provider Signature: _____ **Date:** _____
(For prescription medications)

Pursuant to HIPAA regulations, 45 C.F.R. §164.506 and § 1654.501, I may disclose protected health information regarding this student's treatment activities to be implemented by Metro Nashville Public School and the school nurse program.

STUDENT AND PARENT STATEMENTS

I take full responsibility for taking my own medication during school hours as prescribed by my health care provider. Medicine bottles will have the proper pharmacy label. If non-prescription medication, it must be in original container.

Student Signature _____ **Date** _____

I give consent for my child (name): _____ ***to take his/her own medication during the school day assisted by school personnel as necessary.***

I agree that Metropolitan Nashville Public School System (MNPS), its employees and agents shall not be held liable for any injury resulting from my student's possession and self-administration of the above described medication while on school property or at a school related event. I shall indemnify and hold harmless MNPS, its employees and agents against claims against the possession and self-administration of the above described medication by my student. I understand that all prescription medications provided to the school for use must be labeled by the pharmacist and in the original container and all over the counter medications must be in original containers. I understand that to properly perform this medication assistance, the school nurse program may require clarification from the health care provider to assist them in the treatment activities that I have requested. I understand that the health care provider may disclose protected health information in consultation with the school nurse.

My child is competent to self- administer the medication with assistance. _____ **Yes** _____ **No** **(Check one)**

Parent/Guardian Signature: _____ **Date:** _____

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