REQUEST FOR: <u>ASSISTED SELF-ADMINISTRATION</u> 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 Last	First Middle	Date of Birt	h / /	
Address		Telephone		
Medical Conditions (Optional)		Cell Phone		
The health care provider may be a medi- To be completed by health care provider. Name of Drug / Purpose of Drug	A new form is required each school year.	vsician assistant (PA), or an adva If non-prescription medication	on, parent must fill out this form	
Date to Start:				
Dosage, Route and Times at Sch				
Does this medication absolutely need to			No If yes, explain:	
	lifferent from the manufacturer's: he age or weight please include utside of these recommendations			
Special instructions for storage	and handling:			
Possible side effects:				
ealth Care Provider Name:				
Address:			<u> </u>	
Health Care Provider Signature: (For prescription medications)	th Care Provider Signature:		Date:	
Pursuant to HIPAA regulations, 45 treatment activities to be implement	C.F.R. §164.506 and § 1654.501, I ma ted by Metro Nashville Public School	y disclose protected health infor and the school nurse program.	mation regarding this student's	
	STUDENT AND PARENT	T STATEMENTS		
I take full responsibility for taking my o proper ph	wn medication during school hours as _j armacy label. If non-prescription medic			
Student Signature		Date		
I give consent for my child (name): during the school day assisted by school	personnel as necessary.		to take his/her own medication	
I agree that Metropolitan Nashville Pul from my student's possession and self-a shall indemnify and hold harmless MN described medication by my student. I pharmacist and in the original contains perform this medication assistance, the treatment activities that I have request with the school nurse.	dministration of the above described of the above described of the against clauderstand that all prescription medical and all over the counter medications school nurse program may require claude.	nedication while on school prop aims against the possession and ations provided to the school for must be in original containers. arification from the health care	erty or at a school related event. I self-administration of the above r use must be labeled by the I understand that to properly provider to assist them in the	
My child is competent to self- adminis	ter the medication with assistance.	Yes No	(Check one)	
Parent/Guardian Signature:		Date:		
Phone Number (in case of emergency):	_()			