

# Tishomingo County Schools

## Authorization for Medications at School – Prescriber

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

List any known drug allergies/ reactions: \_\_\_\_\_

### Prescriber Authorization

Diagnosis: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Route of Administration: \_\_\_\_\_

Frequency/Time to be given: \_\_\_\_\_

Medication start date: \_\_\_\_\_ Medication stop date: \_\_\_\_\_

Does medication require refrigeration? Yes \_\_\_\_\_ No \_\_\_\_\_

Is the medication a controlled substance? Yes \_\_\_\_\_ No \_\_\_\_\_

Is self-medication permitted and recommended for this student? Yes \_\_\_\_\_ No \_\_\_\_\_

Has student been instructed in the safe self administration of this medicine? Yes \_\_\_\_\_ No \_\_\_\_\_

Dose student demonstrate safe self administration techniques? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you recommend this medication be kept "on person" by the student? Yes \_\_\_\_\_ No \_\_\_\_\_

Potential Side Effects/ Contraindications/ Adverse Reactions: \_\_\_\_\_

Treatment in the event of an adverse reaction: (attach additional sheet if necessary) \_\_\_\_\_

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_