SPRINGS PUBLIC SCHOOLS TN EMPOWER ACADEMY

MEDICATION AUTHORIZATION AND WAIVER FORM (for prescription and OTC)

Parent Portion:

Name of Student: _____ Age: _____ DOB: _____ Weight: _____ TNCARE: Y/N

Current Medications: _____

Student Significant Medical History: _____

Drug Allergies: _____

Yes____ No____: My student is able to identify the medication below and reason for medication use in the school setting and is competent to self-administer the medication **with assistance** from trained school personnel. **If not**, medication will be administered per ADM 2-10. I give permission for my student to take the medication below in the school setting. It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the health care provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to- know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Rutherford County School System, the undersigned parent or guardian hereby understands and agrees
that the Rutherford County School System and its personnel shall not be held liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication. (T.C.A. § 49-50-1602)

If the prescribed medication below is outside of the published dosing guidelines and/or is not FDA-approved for use in pediatrics, I authorize my student to take this medication during school hours and hereby release the Rutherford County Board of Education, Rutherford County School System, and its employees, agents, and contractors from any and all claims, actions, demands, and liabilities whatsoever associated with the administration of this medication. (see below)

Signature of Parent/Guardian:_____ Date:_____

PRINTED Parent/Guardian Name: _____

Phone Number:_____ Email _____

Provider Portion: **To be completed by healthcare provider for ALL prescription medications.**
If non-prescription medication, parent must complete with School Nurse. ***Each medication needs a separate form.*** **Please complete all items.**

Name of Medication	Strength Amt. to be given	Route	Time(s)

Diagnosis:	Possible Side Effects:

Physician - If the prescribed medication above is outside of the published dosing guidelines and/or is not FDA-approved for use in pediatrics,
Please add second page to include rationale for prescribing outside the recommendations.

Signature of Licensed Healthcare Provider: _____ Date: _____

PRINTED Licensed Healthcare Provider Name: _____

Name of Practice: _____

Phone Number: _____ Fax Number: _____

This authorization is valid for the one year unless changed or withdrawn by parent or stated here:
End Date if other than above: _____.