Silverdale Baptist Academy
Medication Authorization Form

Tennessee Code 49-5-415 allows the school nurse or designated school employee to assist competent students who are required to take medication during the school day. Medication should be taken at home when possible. If it is necessary for the medication to be given during the school hours, the following form must be completed and signed by parent/guardian and medication must be in original prescription bottle and properly labeled by pharmacist. A separate form is required for each medication.

No medication will be administered to a student without a completed medication form on file.

STUDENT INFORMATION
Student Name_____ Date of Birth_____/_____/ _____

Grade_____ Teacher_____

Medication Allergies: _____

MEDICATION INFORMATION □ **Prescription medication** □ **Non-prescription medication**
Name of Medication_____ Dosage and Route_____

Time of Day_____ Frequency_____ Purpose of medication _____

Possible side effects_____ Special Instructions_____

Start date_____ End date_____

PHYSICIAN AUTHORIZATION
(Required for all prescription medications given more than one week)
The above named student is under my medical care and requires this medication to be given at school.
Physician Name_____ Physician Signature_____

Address_____

Phone_____ Fax_____ Date_____

□ Yes □No Student has physician approval to carry and self-administer asthma inhaler. _____ (initial)
□ Yes □No Student has physician approval to carry and self-administer Epi auto-injector. _____ (initial)

PARENT/GUARDIAN AUTHORIZATION (Required)
I acknowledge that the above named student is competent to self-administer this medication with assistance from the school nurse or designated school employee while in attendance at school. I give permission for my child to self-administer this medication with the supervision of a designated school employee. I grant the school nurse permission, as necessary, to discuss the administration and use of this medication with the above physician. I agree that Silverdale Baptist Academy shall incur no liability and be held harmless against any claims of injury related to the administration of such medication. I give permission for my health care provider and Silverdale Baptist Academy to send and receive a fax of this medical record.
Parent/Guardian Name_____ Phone_____

Parent/Guardian Name_____ Phone_____

Medication received by_____ Quantity_____ Date Rec._____ Exp. Date_____