# MACON ROAD BAPTIST SCHOOL

*11015 Highway 64  Arlington, TN 38002  901-290-5555*

## MR Medication Permission Form

## Over the Counter and Prescription Medicine

Please complete this form and send in with any medication you wish to be administered to your child. All medications must be kept in the nurse's office and administered under the nurse's supervision. Please note that if your child takes a routine prescription medication, we must have a physician's signature on this form.

Student's Name: ______________________________ Date: ________________

Date of Birth:__________ Teacher: __________________________ Grade:__________

### Medication Information

**(To be filled in by Parent/Legal Guardian)**

Name of Medication: ____________________________________________

Reason for taking: ____________________________________________

Dosage:__________ Frequency/Time(s) to be Administered:__________

Starting Date: __________ Ending Date:__________ Special Instructions:________________

Does medication require refrigeration? Yes No

Has the student taken this medication in the past? Yes No

**(First dose must be given at home)**

Potential Side Effects/Contraindications/Adverse Reactions: ______________________________

Parent Authorization I authorize the school nurse, and in her absence, any unlicensed school personnel who have been designated by the school, to assist my child in taking the above medication. I understand that additional parent signed authorizations will be necessary if the dosage of the medication is changed. I also authorize the school nurse to talk with my child's doctor/pharmacist should a question come up about the medication, and I agree to notify the school if my child's condition changes. I understand that medication must be registered with the school nurse or the MRBS office. I understand that OTC medication must be in the original, unopened, sealed container which is labeled with the child's name, and that it must accompany this signed form containing specific instructions as to when and why such medications may be necessary, I hereby release MRBS, it's directors, officers, school nurse, employees, and agents from any and all liability, of any nature and character, which may be alleged to arise out of or relating to assistance with the OTC medication described above, provided such is in substantial conformity with the above instructions.

Parent's Signature: ________________________________ Date: __________

Cell Number (best way to contact you): ________________________________

### Physician's Signature for Routine Prescribed Medication

I authorize that the medication listed above is prescribed for the student listed above.

Physician's Signature:______________________________ Date: ____________

*If the prescribed medication is a routine prescription medication for a chronic health issue, allergy, ADHD, depression, etc.

# MACON ROAD BAPTIST SCHOOL

*11015 Highway 64 Arlington, TN 38002 901-290-5555*

**Waiver for Students Who Must Carry Medication on Their Person**

Waiver for Students Who Must Carry Medication on Their Person According to Tennessee Statute 49-5-415, any student that must carry a medication on their person during school hours must provide a "written statement from the prescribing health practitioner" and also have "been instructed in the self-administration of the prescribed" medication. Also required in this statute, is a statement acknowledging that the school and employees would incur no liability should any injury be sustained by the student during self-administration of this medication during school hours. To meet all state regulations, we are now requiring a doctor's signature and a signed waiver of liability if you feel that your student must carry their medication independently. We will need this form signed and returned no later the first week of school. We appreciate your understanding and patience as we strive to maintain optimal safety for your student here at Macon Road Baptist School.

Student's Name: ________________________________________

Name of Medication: ________________________________________

I acknowledge that Macon Road Baptist School shall incur no liability and shall indemnify the school and its employees against any claims relating to the possession or the self-administration of any medication.

Parent's Signature: ________________________________________ Date: _______________