Trousdale County Schools

PHYSICIANS FORM FOR MEDICATION & PROCEDURES

The Trousdale County Board of Education requires the following information when students need prescription or over-the-counter medication and/or procedure at school. This form must be completed & signed by the physician and parent/guardian before medication can be accepted or a procedure can be performed.

1. Student's Name_______________________________ DOB______________
2. Address____
3. School______________________________ Grade________ Teacher__________

_____________________________ __________ __________ __________
Parent/Guardian Signature Date Phone # Cell #

_____________________________ __________ __________ __________
Emergency Contact Relationship Phone # Cell #

PARENT/GUARDIAN AUTHORIZATION

I request that school personnel assist_____________________________ to self-administer the medication listed while at school and away from school during school activities. It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I hereby agree to release Trousdale County School System and its personnel from any legal claim that they now have or thereafter have arising out of the administration or failure to administer this medication. I will assume full responsibility for any side affects and complications that my child may have as a result of taking this medication. My child is competent to self-administer his/her medication with assistance. I understand that it is my responsibility to furnish this medication.

TO BE COMPLETED BY PHYSICIAN ONLY

4. Medication _____________________________ Dosage/Time__________________
5. Student competent to self-administer medication with assistance? Yes____ No____
6. Does the student use an inhaler? ____ Yes ____ No
   Has the student been taught to administer their inhaler? ___ Yes ____ No
   Will the student need assistance with their inhaler? ____ Yes ____ No
7. Dates to administer medication at school From____________ To ___________
8. Side Effects____
9. Allergies____

PROCEDURE

10. Procedure____
11. Student competent to perform procedure? Yes_____ No____
12. Time(s) performed at school __________________________________

_____________________________ __________ __________ __________
Physician's Signature Date Office # Fax #

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Release of Information

Release to: Trousdale County Schools

Any information and materials that may contribute to the school adjustment or assessment of my son/daughter, these parties having a legitimate educational/medical interest in the materials.

Please include educational, psychological, and/or medical information.

____
Physician's Name

____
Physician's Phone Number

____
Student's Name

____
Birthdate

____
School's Name

____
Signature of Parent/Legal Guardian

____
Date

This release is necessary to allow the nurse(s) to communicate with the physician regarding medical conditions or medications.