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Mobile County
PUBLIC SCHOOLS

P. O. Box 180069 • Mobile, AL 36618 • www.mcpss.com
Superintendent Chresal D. Threadgill

Dear Parents,

As the end of the school year approaches, please remember the following points pertaining to your child's medication at school.

1. All medication/medical supplies **must** be picked up by 1:30 PM on **Thursday, May 23, 2024.** This includes pills, injections, drops, ointments, inhalers, liquids, empty bottles, blood glucose monitors, nebulizers, spacers, or any other medical related items.
2. Any of the above items not picked up by 1:30 PM on **Thursday, May 23, 2024**, will be disposed of properly. No medication/supplies may remain at the school during the summer.
3. **Medication will not be sent home with the child**. A parent or adult designee must pick up medication from the school.

NEXT SCHOOL YEAR

1. Enclosed is a medication permission form for medication to be given at school for the next school year. Please have this form completed by your child's physician during the summer. Provide the school with the completed form along with your child's properly labeled medication when your child returns to school. **A parent or adult designee must bring the medication to the school.**

Please remember the following points.

1. *A School Medication Prescriber/Parent Authorization* form **must** be completed by the prescribing physician and signed by parent/guardian before medication can be given at the school. Be sure to include student weight.
2. Medication **must** be in the original, and properly labeled container when brought to the school – the label **must** have the child's name, doctor's name, name and dosage of medication, frequency, and route.
3. Over the Counter medication **must** be ordered by the doctor, must be **unopened** and *School Medication Prescriber/Parent Authorization* form **must** be completed.
4. All public schools in Mobile County require the same medication form. Please use this same form even if your child will be going to a different public school in Mobile County.

Thank you in advance for following our medication administration policy. The safety of your child is especially important to us.

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _____ - _____

STUDENT INFORMATION

Student's Name: _____ **School:** _____

Date of Birth: ____/____/_____ **Age:** _____ **Grade:** _____ **Teacher:** _____

☐ **No known drug allergies—if drug allergies list:** _____ **Weight:** _____ pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ **Dosage:** _____ **Route:** _____

Frequency/Time(s) to be given: _____ **Start Date:** ___/___/___ **Stop Date:** ___/___/___

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance?	Yes	No
Is self- medication permitted and recommended?	Yes	No
If "yes" I hereby affirm this student has been instructed On proper self-administration of the prescribe medication.		
Do you recommend this medication be kept "on person" by student?	Yes	No
Emergency Drug required during Bus Transportation	Yes	No
Cake Icing Gel ONLY for Diabetic Student during Bus Transportation	Yes	No

Printed Name of Licensed Healthcare Provider: _____ **Phone:** ( ) _____-_____ **Fax:** _____-_____

Signature of Licensed Healthcare Provider: _____ **Date:** _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant. OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ **Date:** ___/___/___ **Phone:** ( ) _____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ **Date:** ___/___/_____ **Phone:** ( ) _____-_____