411 East Chestnut Street, Charleston, MS 38921
662-647-5524 | Fax 662-647-3720
www.etsd.k12.ms.us

AUTHORIZATION TO ADMINISTER MEDICATION OR PROCEDURE

PARENT/GUARDIAN AND LICENSED PRESCRIBER AUTHORIZATION REQUIRED

SCHOOL YEAR Complete a new form for each school year and whenever the medication, dosage, time, route, procedure, or prescriber order changes.

Student	_____ Date of birth: _____
School/grade/teacher	_____
Parent/guardian	_____ Daytime phone: _____
Emergency contact	_____ Phone: _____
Allergies	☐ None known ☐ Yes: _____
Diagnosis/reason	_____

LICENSED PRESCRIBER ORDER	
Medication/procedure	_____
Dose/amount	_____ Route/site: _____
Time/frequency	_____
Start/end dates	_____ through _____
PRN indication	Give when/for: _____
Repeat/minimum interval	_____
Maximum school-day dose	_____
Expected effect	_____
Side effects/precautions	_____
When to call prescriber	_____
Emergency instructions	_____

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Prescriber name/credentials	_____
Clinic address	_____
Phone/fax	_____
Signature/date	_____ _____

SELF-CARRY AND SELF-ADMINISTRATION

☐ Student may carry and self-administer prescribed inhaler.

☐ Student may carry and self-administer prescribed epinephrine auto-injector.

☐ Student may carry and self-administer other medication only as permitted by law and ETSD policy.

☐ Student has demonstrated knowledge, technique, maturity, and responsibility.

☐ Backup medication should be stored at: _____.

☐ Student should NOT self-carry/self-administer; trained school personnel will administer.

_____ _____

Licensed Prescriber Signature / Date

Parent/Guardian Signature / Date

PARENT/GUARDIAN CONSENT AND ACKNOWLEDGMENT

- I authorize trained ETSD personnel to administer the medication or procedure exactly as ordered above and consent to necessary communication between the prescriber, pharmacist, emergency responders, and appropriate school personnel.
- I will deliver medication to the school in the original, properly labeled pharmacy or manufacturer container. The label and order must match. Students may not transport medication unless specifically authorized.
- I will provide medication and supplies before the expiration date, notify the school in writing of changes, and retrieve unused items by the announced deadline. Unclaimed medication may be disposed of according to policy.
- I understand that school health staff may request clarification before administering an incomplete, conflicting, expired, unsafe, or illegible order.
- This authorization applies during the current school year, including district-sponsored activities when appropriate arrangements are made in advance.

_____ _____

Parent/Guardian Signature / Date

Best Daytime Phone / Email

SCHOOL HEALTH OFFICE USE

Order reviewed by/date	_____
Medication received	Date: _____ Quantity: _____ Expiration: _____ Initials: _____
Storage location	_____
MAR/procedure log started	☐ Yes Date: _____ ☐ Not applicable
Staff training/delegation	_____
Field trip/activity plan	☐ Completed ☐ Not applicable Notes: _____

CONTACT Return the completed form to the student's school health office. District office: 411 East Chestnut Street, Charleston, MS 38921 | 662-647-5524 | www.etsd.k12.ms.us