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MEDICINE ADMINISTRATION FORM

To Be Completed By Parent/Guardian

Student Name:_____
Last First Middle

Race: _____ Height: _____ Weight: _____ Sex:_____

Date of Birth:_____ Social Security #_____

Parent:_____ Street Address:_____

City:_____State:_____Zip:_____Phone:_____

_____ I request that my child (named and identified above) receive medication as prescribed by our physician.
_____ My child is not currently receiving prescription medication.

GENERAL MEDICATION USE PERMISSION FORM

The MSA Health Center keeps the following medications on hand. These medications will be administered only according to your indications below. Only non-ephedrine medications will be administered. Ephedrine requires a prescription in accordance with Mississippi law. (When available, we will stock generic brands.) **All students must report all prescription and over the counter medications to the School Nurse. The nurse or other authorized personnel must store and administer all prescribed medications except asthma inhalers.**

	Use OK	Do Not Use	Use Only with Parent Contact
Tylenol			
Advil			
Aleve			
Motrin			
Excedrin			
Pepto Bismol			
Mylanta/Maalox			
Kaopectate			
Chloraseptic			
Cough Drops			
Benadryl			
Sudafed			
Imodium			
Emetrol			
Midol			
Salt (for throat gargles)			
Neosporin Ointment			
Cortaid			
Caladryl			
Calamine Lotion			
Hydrogen Peroxide			
Tinactin			

I authorize the School Administration or Nurse to assign unlicensed school personnel who has completed the Mississippi Board of Nursing *Assisted Self Administration Curriculum* the task of assisting my child in taking the above medications and any prescription medications from this date forward. I understand that additional parent/prescriber signed statements will be necessary if the dosage or type of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question arise about the medication. Medication must be registered by the school nurse. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate.

Parent/Guardian _____ Signature _____

Phone Number _____ Date _____

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MEDICAL EXAMINATION FORM

TO BE COMPLETED BY PHYSICIAN

Student Name:_____
Last First Middle

Race: _____ Height: _____ Weight: _____ Sex:_____

Height: _____ft. _____in. Weight: _____lbs. Pulse: _____

Blood Pressure: _____

Eyes: Are glasses worn? Yes ( ) No ( ) Is color vision defective? Yes ( ) No ( )

Ears: Is hearing normal? Yes ( ) No ( ) Are drums intact? Yes ( ) No ( )

Skin Normal ( ) Abnormal ( )
Head, Face, Neck Normal ( ) Abnormal ( )
Nose and Sinuses Normal ( ) Abnormal ( )
Mouth and Throat Normal ( ) Abnormal ( )
Teeth Normal ( ) Abnormal ( )
Lungs and Chest Normal ( ) Abnormal ( )
Heart Normal ( ) Abnormal ( )
Vascular System Normal ( ) Abnormal ( )
Abdomen Normal ( ) Abnormal ( )
Endocrine System Normal ( ) Abnormal ( )
Spine Normal ( ) Abnormal ( )
Neurologic Normal ( ) Abnormal ( )

Are muscle strength and function of extremities normal and all digits present? Yes ( ) No ( )

DETAILS OF ABNORMALITIES NOTED ABOVE:

_____
_____
_____

May this person, without harm to his/her health, participate in the following:

Sports Yes ( ) No ( ) Swimming Yes ( ) No ( )
Moderately Strenuous Exercises Yes ( ) No ( ) Dance Class Yes ( ) No ( )

PHYSICIAN'S OPINION: Are there or have there been any physical or emotional problems that are likely to interfere with the student's adjustment to a residential school environment or athletic activities? Yes ( ) No ( )

If "YES", please explain:_____
_____

Please itemize all regular prescription medications on the Prescription Medicine Form.

PHYSICIAN SIGNATURE: _____DATE OF EXAM:_____

ADDRESS:_____

Prescription Medicine Form

Note: This section must be filled out whenever a new medication is prescribed. All students must report all prescriptions to be stored and administered through self-administration except asthma inhalers.

Student Name _____ Grade _____

To Be Completed by Physician (if medicine is prescribed below):
I request that my patient (named and identified above) receive the following medication while in residence at the Mississippi School of the Arts.

Diagnosis: _____

Name of Medication: _____

Prescribed dosage and means of administration:
_____
_____

Time(s) to be administered: _____

Expected duration of treatment: _____

Possible side effects/adverse
reactions:_____

Physician's Name _____Signature _____

Phone Number _____ Date _____