SENATOBIA MUNICIPAL SCHOOL DISTRICT
104 McKie Street
Senatobia, MS 38668
Chris D. Fleming
Superintendent of Education

Bernice T. Jackson
Assistant Superintendent

April Scott, Ed. D.
Assistant Superintendent

Medication Authorization Form

School Year: _____

Child's Name:_____ DOB:_____

PHYSICIAN'S ORDER SECTION:

Name of Medication:_____

Dosage:_____ Time(s) to be given:_____

Reason for Medication:_____

Termination date at the end of current school year:_____

List ONLY side effects that must be reported to parent or MD:_____

☐ 4k-5th grade students may not self-administer any medications.

☐ 6th-12th grade students may self-administer only insulin/glucagon, asthma inhalers, and/or EpiPens.

☐ Child may self-administer medication with supervision

☐ Child may NOT self-administer medication

Physician's Signature:_____ Date:_____

Address:_____ Phone:_____

PARENTS COMPLETE THIS SECTION:

I agree with the above Physician Order and request this medication be given to my child as ordered above.

Parent Signature:_____ Date:_____