# MISSISSIPPI SCHOOL FOR MATHEMATICS AND SCIENCE

## PRESCRIPTION MEDICATION FORM

Student Name: ___________________________________________ Date of Birth: __________________
Last First Middle

**This form MUST be completed regardless if your child in currently on any medication.**

**<u>All</u> prescription medication *<u>must</u>* be registered with the Residence Hall Director. This form must be completed whenever a new medication is prescribed or an existing prescription expires. This includes all psychotherapeutic drugs and medicines also.**

**Both the parent & healthcare provider must give consent for self administration of medication before a student is permitted to keep their medication in their dorm room. However, not all medication will be permitted in dorm rooms (even if both the parent & physician give consent). These medications include all controlled substances and non-controlled anti-psychotic medication.**

**SECTION I: To Be Completed by Parent/Guardian:**

☐ I give my child permission to self administer, on his/her own, current medication as well as medication prescribed by the MUW Health Center & other local facilities, in their dorm room, in compliance with MSMS school policy with the exception of those prohibited below.

☐ I request that my child **NOT** be allowed to self-administer the following medication(s) or to keep said medication(s) in his/her dorm room: ***(Please note that all controlled substances and non-controlled anti-psychotics will not be permitted in student dorm rooms)***

_______________________________________________________________________________

☐ I wish to be notified regarding how my son/daughter is taking his/her medicine.

Signature of Parent/Guardian: ________________________________ Date: _____________________

**SECTION II: To Be Completed by Physician:**

Diagnosis: _______________________________________________________________________________

Name of Medication: ______________________________________________________________________

This medication ☐ IS ☐ IS NOT a controlled substance or non-controlled anti-psychotic.

The student ☐ MAY ☐ MAY NOT self administer this medication.

Prescribed dosage & means of administration: ________________________________________________

_______________________________________________________________________________

Time(s) to be administered: _________________________________________________________________

Expected duration of treatment: _____________________________________________________________

Possible side effects/adverse reactions: _______________________________________________________

Are there interactions with over-the-counter medications that we should be aware of? ______________

_______________________________________________________________________________

Physician's Name: _____________________________Physician's Signature: __________________________

Phone Number: ______________________________ Date: _______________________________________