Form C
MISSISSIPPI SCHOOL FOR MATHEMATICS AND SCIENCE

PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS

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

This form MUST be completed regardless if your child is currently taking 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: ____

Form C
MISSISSIPPI SCHOOL FOR MATHEMATICS AND SCIENCE

OVER-THE-COUNTER MEDICATION USE PERMISSION

Student Name: ______________________________________ Date of Birth: ________________
Last First Middle

Below you will find listed several medications we will keep on hand, but that will be given out only with staff discretion, instruction and according to the permission you indicate below. We will carry a comparable generic form).

Tylenol	Neosporin Ointment	NyQuil Day and Night
Ibuprofen	Salt (for throat gargles)	Benadryl
Mylanta/Maalox	Hydrogen Peroxide	Dramamine
Kaopectate	Sudafed	Emetrol
Chloraseptic	Robitussin	Imodium
Cough Drops	Mucinex	Midol

If you have any objections to the use of any of these medications by your child, please indicate which ones and why: ____

____

Parents: We do not wish to become a dispensary for the medical needs of your child. Please discuss and supply your child with those everyday items that will help prevent the worsening of an illness or problem, or help them recover quickly from the minor aches, illnesses, and pains they may experience. Help us keep them healthy. **Important: If your child brings medications from home, either prescription or over-the-counter, he/she may NOT share them with other students under any circumstances. Please stress this to your child.**

_________________________________ ____________________
Parent (Legal Guardian Signature) Date