

Parent/Guardian Authorization of Medication at School

(Complete one form for each medication)

Student Name: _____ Birth Date: _____
 School Name: _____ Teacher: _____ Grade: _____

Only those medications that are medically necessary during school hours for a student's attendance or written in an IEP should be sent to school. Children's AISD Student Health Services and AISD require the following:

- Parent/Guardian written authorization for medication administration at school
- Medication in the original, properly labeled container (name of medicine with strength, dosage and directions; name of prescribing physician who is licensed in Texas; current date)
- Medication label contains the student's first and last name
- Non-prescription medication dosage must agree with manufacturer's recommendations or a physician's order will be required.
- The first dose of this medication for the current condition/illness **may not be given at school.**
- **Asthma inhalers may be carried and self-administered, if approved by the School Nurse.**

Please complete the following:

Medication Name and Strength	Dosage	Time(s) to be Given at School	How it is Taken (mouth, eye, ear, nose, tube, on the skin, etc.)	Reason/ Medical Condition for which Medication is given	Additional Comments

Medication Start Date: _____ Medication Stop Date: _____

When was the first dose of this medication given for this illness/condition? _____

Date and Time

1. I request that the above medication be given during school hours as ordered by this student's physician. I also request that the medication be given on field trips, as prescribed with adequate notification from me.
2. I release school personnel from liability in the event adverse reactions result from taking the medication.
3. I will notify the school of any change in the medication, (dosage change, time change, etc.).
4. I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action(s) of the medication.
5. I give permission for the school nurse to consult with the above student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by the medication.
6. I give permission for the medication to be given by trained school personnel as delegated by the Principal.
7. My child _____ **may/may not** carry the medication home when the school year ends.

Circle One

 Parent/Guardian Printed Name Day Phone Home Phone

 Parent/Guardian Signature Date Relationship to Student

Reviewed by RN _____	SHA _____	may/ _____	may NOT administer this medication
Date			
RN PRINTED Name: _____	RN Signature: _____		