Humble Independent School District Health Services

Authorization and Permission for Administration of Medication

☐ In eSchool
Nurse Initial_____
Expiration Date
_____

Guidelines for acceptance and administration of medications in Humble ISD are available from the campus nurse.

Students Name_____ **DOB**_____
Last **First** **MI**

PARENT/GUARDIAN SECTION

Medication name **Strength** **Dosage** **Route** **Time**

Start Date_____ Allergies_____

Special Instructions/Duration_____

Condition for which drug is to be given_____

Medications currently taken at home_____

Note: Non-prescription medications taken more than 4 times in a month and prescription PRN medication will require a physician's order (signature is required) indicating maximum dosage allowed per month.

PARENT: PLEASE SIGN AT THE BOTTOM OF THE MEDICATION FORM

PHYSICIAN'S SECTION: PLEASE WRITE ORDER FOR SCHOOL ADMINISTRATION

Parent approval for release of information indicated below. Prescription medication given more than 10 days, non-prescription medication given more than 4 times in a month, or in excess of recommended dosage on the container and all prescription PRN medications require a physician's order.

Medication name **Strength** **Dosage** **Route** **Time**

Start Date_____ Allergies_____

Special Instructions/Duration_____

Condition for which drug is to be given_____

Medications currently taken at home_____

Physician's name (print)_____ **Physician's signature**_____

Phone number_____ **Fax number**_____ **Date**_____

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication.
Completion of this form acknowledges your review of and agreement to follow all district medication guidelines.

Parent's Signature _____ **Date**_____
Daytime Phone_____ Alternate phone _____