Humble Independent School District Health Services

Authorization and Permission for Administration of Medication

☐ In eSchool
Nurse Initial_____
Expiration Date
____

Students Name____ **DOB**__________________
Last **First** **MI**

- **ALL MEDICATION MUST BE DELIVERED TO AND PICKED UP FROM THE CLINIC BY A PARENT OR AUTHORIZED ADULT.**
- Parent signature is required for **ALL** medications to be given at school.
- Physician signature is required:
  - For all prescription medications and non-prescription medication given more than 10 consecutive school days.
  - For all PRN (as needed) medications (Prescription or Non-Prescription) given more than 4 times per month.
- Prescription and non-prescription medications must be in original, fully-labeled container. All medications must also be unexpired and age appropriate. (Pharmacies will usually provide cost-free additional labeled containers upon parent request.)
- Labels must include patient name, medication name, directions for use and date.
- Parental permission to give "missed doses at home" must be in writing. Fax and e-mail are allowed.
- Changes to prescription medication administration such as dose and/or time require a physician written order.
- Changes to non-prescription medication administration such as dose and/or time must be in writing from the parent.
- Discontinuance of medication must be in writing from the parent and/or physician.
- Medication orders are valid for current school year/summer school

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 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 non-prescription medication when dosage is more than the recommended dosage on the container require a physician's order.

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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.

Parent's Signature________________________________ **Date**________________________________
Daytime Phone____________________________________ Alternate phone ____________________________