



Humble Independent School District Health Services
 Authorization and Permission for Administration of Medication

<input type="checkbox"/> In eSchool
Nurse Initial _____
Expiration Date _____

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

Students Name _____ Last _____ First _____ MI _____ DOB _____

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 _____