



Administration of Medications at School Authorization Form

Student's Name: _____ DOB: _____

Campus: _____ Grade: _____ Allergies: _____

PART 1- TO BE COMPLETED BY THE PARENT/GUARDIAN

Prescription: New Renewal

If new, the first full day's dosage was given at home on: _____

List all medications student is taking, including over-the-counter medications:

I hereby request and authorize The University of Texas at Tyler University Academy staff to administer prescribed medication as directed by the physician. I agree to release, indemnify, and hold harmless The University of Texas at Tyler University Academy and any of their staff members from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided The University of Texas at Tyler University Academy staff are following the physician's order as written in Part II below. I have read the procedures outlined on the back of this form and assume the responsibilities as required.

Parent/Guardian Signature

Phone Number

Date

PART II-TO BE COMPLETED BY THE PHYSICIAN (signature required)

The University of Texas at Tyler University Academy discourages the administration of medication to students in school during the school day. Any necessary medication that possibly can be administered before and after school should be so prescribed. Only non-parenteral medications are administered except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication to students during the school day and while participating in outdoor education programs and overnight field trips, according to the procedures outlined in the following sections.

Please List Each Medication Separately

Name of Medication: _____ **Dosage:** _____ **Time:** _____
Trade name and/or generic Ranges not accepted (i.e. 1-2 tabs)

Special instructions: _____

Condition for which the medication is prescribed: _____

Side-effects and precautions: _____

Route of Administration: _____

Effective Dates: _____ to _____

Name of Medication: _____ **Dosage:** _____ **Time:** _____
Trade name and/or generic Ranges not accepted (i.e. 1-2 tabs)

Special instructions: _____

Condition for which the medication is prescribed: _____

Side-effects and precautions: _____

Route of Administration: _____

Effective Dates: _____ to _____

Name of Medication: _____ **Dosage:** _____ **Time:** _____
Trade name and/or generic Ranges not accepted (i.e. 1-2 tabs)

Special instructions: _____

Condition for which the medication is prescribed: _____

Side-effects and precautions: _____

Route of Administration: _____

Effective Dates: _____ to _____

*****PLEASE ATTACH A SEPARATE SHEET IF ADDITIONAL MEDICATIONS ARE REQUIRED*****

If PRN, please specify:

When indicated (signs/symptoms): _____

Frequency of administration: _____

Ranges not accepted (i.e. every 2 to 4 hours)

Physician's Signature: _____ **Physician's Printed Name:** _____

Physician's Telephone: _____ **Fax:** _____ **Date:** _____

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medications such as inhalers and EpiPens® **must** be authorized by the prescriber and be approved by the school nurse according to the State Medication policy.

Prescriber's authorization for self-carry/self-administration of emergency medication:

Physician's Signature _____ **Date** _____

School (RN)/Principal's approval for self-carry/self-administration of emergency medication:

School Nurse/Principal Signature _____ **Date** _____

PART III-TO BE COMPLETED BY THE PRINCIPAL OR SCHOOL NURSE

Check as appropriate:

- Parts I and II above are completed, including signatures. (It is acceptable if all items of information in Part II are written on the physician's stationary/prescription blank)
- Prescription medication is properly labeled by a pharmacist.
- Medication label and physician order are consistent.
- Over-the-counter medication is in an original container with the manufacturer's dosage label and safety seal intact.

Date any unused medication is to be collected by the parent or guardian (within one week after expiration of the physician's order): _____

School Nurse/Principal Signature

Date