Medication Administration Authorization

Student's Name: _____ Student ID#:_____
School: _____ Grade: _____ Date of Birth: _____
Allergies: _____
Pharmacy: _____Pharmacy telephone #: _____

This form must be filled out completely in order for school health staff to administer medication to a student. A new medication authorization form must be completed at the beginning of each school year, for each medication, and each time there is a change in the medication's administration instructions. The following is required by the provider of the medication according to Texas Education Code, Chapter 22, Section 22.052:

- ***Prescription and non-prescription medication must be delivered to school in its original container.***
- ***The container must be properly labeled by a pharmacist or the prescribing physician.***

Parent Permission

☐ *I request that authorized persons (clinically trained designee of the principal) at my child's school assist my child in taking the prescription or over-the-counter medication(s) described below at the time indicated and as designated by his/her licensed prescriber.* ***Medication doses that could be taken at home will not be administered at school.***

☐ *I request that my child be allowed to self-carry and self-administer medication.****(Insulin Pump and Inhaler only)*** *I shall hold harmless and indemnify the Cleveland ISD, its agents, employees, and board members against all claims, judgments, or liability arising out of self-administration and carrying of medication by my child. (****For Middle School or High School students only****)*

☐ I give consent for my child's medical information to be displayed in the school's electronic documentation system.

I, or a responsible adult, will be responsible for bringing the prescription and/or over-the-counter medications to the school clinic in the original labeled container from the pharmacist or the manufacturer's container. (Prescription labels must include ***date, name of patient, name of medication, dosage and physician's name and expiration date****.)* **DO NOT SEND ANY MEDICATION ON THE BUS**

I also understand that I am responsible for maintaining enough of the medication at the school. Failure to do this will result in an interruption of the licensed prescriber's order or discontinuation of the school's administration of the medication for my child. I understand that, if my child refuses to take the medication(s) the medication(s) will not be given, and the parent will be notified.

School personnel have permission to communicate with the licensed prescriber regarding use, side effects, response, and contraindications of the medication(s).

☐ *I confirm that my child has previously taken this medication.*

☐ *My child has not previously taken this medication, but this is an emergency medication.*

All medication not picked up by a parent or guardian by the last day of instruction will be destroyed.

_____ _____ _____
Signature of Parent/Legal Guardian ***Relationship*** ***Date:(Mo./Day/Yr.)***

_____ _____ _____
Printed Parent Name ***Cell Phone number*** ***Home Phone Number***

Licensed Prescriber Authorization:

I am prescribing the following medication(s) for the above student to be administered at school.

Printed Licensed Prescriber's Name:_____

Address:_____

Daily

Name of Daily Medication (Generic and Trade Name)	Diagnosis	DOSE (mg, mcg)	ROUTE (PO, GT, SC, IV)	Frequency	Time(s) (AM/PM)	Possible Adverse Side Effect or Contraindications	Authorized to self-carry and self-administer
							☐
							☐
							☐
							☐

PRN

Name of Daily Medication (Generic and Trade Name)	Diagnosis	DOSE (mg, mcg)	ROUTE (PO, GT, SC, IV)	Frequency	Time(s) (AM/PM)	Possible Adverse Side Effect or Contraindications	Authorized to self-carry and self-administer
							☐
							☐
							☐
							☐

OTC

Name of Daily Medication (Generic and Trade Name)	Diagnosis	DOSE (mg, mcg)	ROUTE (PO, GT, SC, IV)	Frequency	Time(s) (AM/PM)	Possible Adverse Side Effect or Contraindications	Authorized to self-carry and self-administer
							☐
							☐

The above orders shall be effective throughout the current school year, summer school and through September 30th of the following school year, unless the orders are discontinued, changed or withdrawn in writing by the parent before that time elapses.

_____ _____

Licensed Prescriber's Signature **Date (Mo./Day/Yr.)** **Telephone/Fax Number**

Medication Administration Authorization

Contract for Student Self-Carry and Self-Administration of Medication

Student Name:_____**DOB:**_____

Name of medication:_____

- ☐ Student has been instructed on the proper use of the medication.
- ☐ Student has demonstrated, to the school nurse, proper technique for medication administration.
- ☐ Student has demonstrated appropriate self-management skills.
- ☐ Student will maintain a written record of their medication administration at school (i.e., in school planner, notebook, etc.).
- ☐ **Student agrees to follow instructions from licensed prescriber.**
- ☐ **Student agrees to follow all relevant school district policies.**
- ☐ **Student will not allow any other person access to their medication.**
- ☐ Student agrees to keep the current supply of medication in a secured location (i.e., backpack, purse, etc.).
- ☐ Student will keep a spare supply of medication in the campus clinic.
- ☐ Student agrees to have medications refilled before they run out.
- ☐ **Student agrees to check in with the school nurse**.

  □ **Daily** □ **Weekly** □ **Monthly** □ **Other: _____**

- ☐ **Student agrees to notify the school nurse for the following circumstances:**
  - ☐ Student has an increase in symptoms.
  - ☐ Symptoms are not relieved by medication.
  - ☐ Student suspects they are having side effects from medication.
  - ☐ Other:_____

Student Name: _____

Date:_____

School Nurse Signature: _____

Date:_____

If the school nurse does not concur with the health care provider's instructions after assessing the competencies of the student, the school nurse will contact the health care provider to attempt to agree upon a plan. Permission for the self-administration of medication may be suspended if the student is unable to maintain the procedural safeguards established in the above agreement.

Comments:_____

_____

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