Cleveland Independent School District
Medication Authorization Form

Student Name _____ **Date of Birth** _____

Student ID# _____ **Campus** _____ **Grade** _____

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 administration instructions.

In Compliance with the Cleveland ISD board policy FFAC (local), all medications administered by Cleveland ISD must be:

- Delivered to the clinic by a parent/guardian or his/her designee (responsible adult).
- Prescription medications must be in the original container and be properly labeled. The label must include the date prescribed, pharmacy name and address, prescription number, student's name, prescriber name, directions for use, and any cautionary statements. The directions on the label must match the doctor's order. It must be prescribed by a physician or dentist licensed to practice in the United States.
- Over-the-counter medication must be in the original manufacturer's packaging and will only be administered in accordance with the manufacturer's guidelines that are age/weight appropriate for the student unless otherwise prescribed by a physician. There must be a physician's order for over-the-counter medications.
- Medication not retrieved from the clinic by a parent/guardian or his/her designee (responsible adult) by the last calendar day of the current school year will be destroyed in accordance with Cleveland ISD procedures.

Medication Name:			**Medication Unit (mg/mcg etc.):**		
Medication Dosage: (Amount to be given)			**Special Instructions:**		
Time to Be Given:	❑ **Breakfast**	❒ **Lunch**	❒ **PRN/ As Needed**	❒ _____ **(Specific time)**	❒ **Missed AM home dose** ***(if verified by parent)***
Period of Administration:	❒ **30 days**	❒ _____**days**	❒ **Duration of school year**	❒ **As needed for emergency**	
Route of Administration:	❒ **Oral**	❒ **Inhaled**	❒ **Nasal**	❒ _____	
❒ **THIS IS AN EMERGENCY MEDICATION**		❒ **STUDENT MAY SELF-CARRY EMERGENCY MEDICATION**		❒ **STUDENT MAY SELF-ADMINISTER EMERGENCY MEDICATION**	
Reason for Medication:					
Possible Side Effects:					
Medications currently taken at home:					

I authorize school personnel to administer the above medication during school hours. I authorize the school's registered nurse or her designee to contact the prescribing physician regarding any clarifications needed regarding the medication listed above as required to ensure safe administration. I understand if the circumstances are questionable, the school employee reserves the right to deny my request while investigating.

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN	TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER
Parent/ Legal Guardian Printed Name:	**Healthcare Provider Printed Name:**
Parent Phone:	**Provider Phone:**
I have completed and reviewed this form; all of the information is accurate.	**Fax:**
Signature:	**Healthcare Provider Signature:**
Date:	**Date:**