MATHIS ISD

MEDICATION AUTHORIZATION FORM

Only medications that are required to enable a student to stay in school may be given at school. Three times a day medication should be given before school, after school, and at bedtime. If necessary, medication can be given at school under the following conditions:

1. **MEDICATION MUST BE IN ORIGINAL PROPERLY LABELED CONTAINERS** dated for the current school year and brought to school by an adult. Medications must be age appropriate.
2. **MEDICATION SENT IN BAGGIES OR UNLABELED CONTAINERS WILL NOT BE GIVEN AND DESTROYED.** All prescription medication must be provided in a container with the pharmacist's label attached. Non-prescription OTC medication must be in the container with the manufacturer's original label. Physician samples must be appropriately labeled by the physician with the patient's name and instructions.
3. **The first day dosage of any medication must have been given at home before it can be administered at school.**
4. An emergency plan for anaphylaxis and asthma + parental permission is required (separate form) for self-carry/self-administered emergency medications such as inhalers/EpiPens/Insulin.
5. FDA APPROVED OVER THE COUNTER MEDICATION MAY NOT BE GIVEN LONGER THAN 7 CONSECUTIVE DAYS WITHOUT A DOCTOR'S WRITTEN PRESCRIPTION.

MEDICATION ADMINISTRATION AT SCHOOL

Student_____**Date**_____**Grade**_____**School Year** _____
Known Allergies: _____

(Form is Valid for the current school year, including summer session.)

Medication	Dose	Time to Be Given	Start/ End Date	Comments

PARENT/GUARDIAN CONSENT:

- I give my permission for the above medication(s) to be given to my child at school or on school sponsored field trips according to the above requirements.
- I understand that the medication may be given by an authorized **MISD** employee in the absence of the medical personnel
- I understand that medication will be destroyed unless picked up by the end of the last day of classes.
- I give permission for my child to transport the above medication(s) home. I accept responsibility for my child and the specified medication. I understand controlled medication will not be sent home with the student.
- I authorize the school nurse to communicate with our health care provider: _____ as allowed by HIPAA.
- I authorize the school to disclose the above information to those within the school district that have a need to know for educational purposes.

Parent/Guardian Signature Date Relationship to Student

Home Phone # Work Phone # Cell Phone #

FOR CLINIC USE ONLY! ☐ **Entered in eSchool** ☐**Teacher Notified** ___/___ ☐ **IHP (if applicable)**

Prescription Medication Count:

Date	# Pills	Nurse Signature	Parent/ Witness Signature	Date	# Pills	Nurse Signature	Parent/ Witness Signature

Comments

Date	Comments	Date	Comments

Date Medication Returned to Parent or Student:
Medication:
Medication:
Parent or Student Signature:
Nurse Signature:
Medication Wasted (Disposed) on Date:
Medication and Quantity:
Medication and Quantity:
Nurse Signature:
Witness Signature:

Date RN Printed Name Review		**RN Signature/ Initials**