**SANGER INDEPENDENT SCHOOL DISTRICT**

***"Dedicated to Education…Committed to Excellence"***

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL**

The Texas State Law (Texas Education Code 22:052) requires physician/dentist/APRN or PA's written order **and** the parent/guardian's written authorization for a nurse to administer prescription medications or, in his/her absence, designated staff to administer medications. Medications must be in pharmacy-prepared containers and labeled with the student's name, name of drug, strength, dosage, frequency, provider, and date of original prescription. (When filling a prescription, please ask the pharmacist for a second bottle for school.) No first dose of any medicine will be administered at school. **Antibiotics will only be given at school if they are prescribed as 4 times a day.**

**PHYSICIAN/DENTIST/APRN/PA ORDER**

Student's Name_____Teacher/grade_____Today's Date_____
Address_____D.O.B._____
Condition for which this medication needs to be administered during school hours_____
_____
Drug (name, dose, and method of administration) _____
_____
Time of administration _____dates to be administered_____
Relevant side effects to be observed _____
If there are side effects, plan for management or special instruction _____
_____
Physician's Printed Name: _____Phone_____Fax_____

Physician's Signature: _____

**Authorization by Parent/Guardian for the administration of the above medication by school personnel**

I agree to hold harmless Sanger ISD and its employees for any consequences resulting from the administration of this medication/treatment. I request that the above medication, ordered by his/her medical provider for my child _____, be administered by school personnel. I understand that I must supply the all medication in original containers dispensed and properly labeled by a physician or pharmacist and will provide no more than a 45 school day supply. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or a week beyond the close of school.
Printed Name: _____ Relationship to child: _____

Signature: _____ Date: _____Phone:_____

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
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| **OCT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NOV** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DEC** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **JAN** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **FEB** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MAR** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **APR** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MAY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **JUN** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| Date | Medication received/notes | count | initials |
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Signature/initials_____

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