Peaster ISD School Health
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Date__________________ Student Name____

D.O.B.____________________ Grade___________________ ALLERGIES: ___________________________

We request, that whenever possible, medications be given during non-school hours. If medication is needed during school hours, the following requirements must be met prior to the student receiving medication:

1. No medication will be administered without the parent/guardian signed consent. This will be kept on file in the Student's Health Record. The parent/guardian is responsible for obtaining any required information from the physician.
2. The medication must be properly labeled and must include:
   a.) Student's name b.) Name of medication c.) Date d.) Dosage and time of administration
   e.) Route of administration f.) Expiration date
3. Over the counter medication must be in its original container with proper label.
4. The first day's dosage of any new medication must be given at home.
5. All medications must be brought to school by the parent/guardian and given to authorized personnel.
6. The parent/guardian is responsible for submitting to the school, in writing from the physician, notification of any change in dosage or time of administration.
7. All medication kept in school will be stored in a secure area accessible only to authorized personnel. (Such storage will be at the risk of the parent/guardian). Peaster ISD personnel will not assume any responsible for possible loss of students' medication.
8. Expired medication will not be given. Parents will be notified of medications that expire during the school year and will be responsible for collecting unused portions of the medication or it will be destroyed.
9. Medication must be picked up by the last day of school year. Any medications left will not be stored over the school break and will be destroyed.

Medication ____________________________________Amount to be given______________________________

Time______________________________ Reason(s) ____

Medication ____________________________________Amount to be given ______________________________

Time______________________________ Reason(s) ____

I have read the procedures above and authorize the school nurse or designee to administer the above medication to my student

Parent/Guardian Signature ____Date_______________________

Nurse /Aide Signature ____ Date _______________________

Office Use Only:

Date ______________ Medication Received____

Expiration Date ___________________ Quantity Received _________________Initials_________________

Date ______________ Medication Received____

Expiration Date ___________________ Quantity Received _________________Initials_________________

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