La Pryor Independent School District
AUTHORIZATION FOR MEDICATION ADMINISTRATION

Name/Nombre: _____ DOB/FDN: _____

School/Escuela: _____ DATE/FECHA: _____

The Doctor must be Licensed Texas Physician
Se requere que el Médico tenga licencia Médica de tejas.

Medication must be in original pharmacy or medication container, to include dosage, time, and method of administration. The medication may be administered by school personnel if schedule falls during school hours of operation.
Se requere el frasco original del medicamento con la etiqueta. La etiqueta debe tener el nombre del niño/niña, nombre de la medicina, horario, dosis, fecha y nombre del Médico.

****Parental Permit to Administer Prescription or Non-Prescription Medication at School for 15 Days or Less****

Student Name: _____ Grade: _____ Teacher: _____
Prescription Medication: ( ) Yes ( ) No Non Prescription Medication ( ) Yes ( ) No

Name Of Drug: _____
Time to be given: _____ Amount to be given: _____
Reason Medication being given: _____

Number of Tablets: ☐ Pills: ☐ Capsules: ☐ Other: ☐

Send only amount student needs to take at school in properly labeled, original container, so that student will not required to carry medication back and forth from home to school:

Parent/Guardian signature: _____ Date: _____

Home Phone: _____ Work Phone: _____

****Physician-Parent Permit to Administer Prescription Medication at School For More Than 15 Days****
(FOR USE BY LINCENSED PRESCRIBER ONLY)

Student Name: _____ Grade: _____ Teacher: _____

Reason student receiving medication: _____
_____

Name of Medication: _____
Dosage: _____ Date To DC: _____

Number Of Tablets: ☐ Pills: ☐ Capsules: ☐ Inhalant: ☐ Liquid: ☐ Other: ☐

Feedback Required ( ) Yes ( ) No If Yes How Often: _____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____