2023-24
Poolville Independent School District
Medication Administration Permission Form

Student's Name _____ DOB _____ ID# _____ Wt. _____lbs.

Condition for which medication is given, side effects for child, pertinent information:

_____

Medication Allergies: ☐ NONE _____

MEDICATION	STRENGTH (ex. 15mg)	DOSE/ROUTE	START & END DATE	TIME TO BE GIVEN	1ST DOSE OF NEW MEDICATION	*MAY GIVE A.M. DOSE (INITIAL)
					YES ☐ NO ☐	
					YES ☐ NO ☐	
					YES ☐ NO ☐	

*Parent initial box above to indicate: Student may take morning (A.M.) dose of medication, if forgotten at home, with telephone/written permission from parent.

- **All prescription medications** must be provided by the parent/guardian and accompanied a signed medication administration permission form. The medication must be in a properly labeled pharmacy bottle and will be given according to those instructions.
- **All over the counter medications** must be provided by the parent/guardian and accompanied by a signed medication administration permission form. The medication must be in the original container with dosing instructions (no blister packs, Ziploc bags, or dosing syringes). These medications will not be given more than 10 doses without a physician's order.
- **All alternative medications** must be FDA approved and will only be administered at school if it is determined educationally necessary as part of the student's IEP or 504 plan. A physician's order is required as well.
- Poolville ISD cannot assume any responsibility for loss or negligent behavior when a student carries his/her medication without the nurse's knowledge.

_____ (parent initials) *Changes in medication or dosage require a new physician's order/signature. Any new or additional medication requests require a new form to be completed.

_____ (parent initials) *Unused, discontinued, or expired medications must be picked up by the parent/guardian. Medications not picked up will be discarded at the end of the year.

I request and authorize Poolville ISD to administer the above medication(s) as prescribed. I understand the school administrator may designate any qualified employee to administer this medication. I authorize the school licensed nurse and prescribing healthcare provider to confidentially discuss or clarify this medication order, and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

_____

(Parent/Guardian Signature) (Printed Name) (Date) (Phone)

****PHYSICIAN/HEALTHCARE PROVIDER****

_____ (physician's initials) I have instructed this student and give my permission for the self-carry of their emergency asthma and/or anaphylactic allergy medication. **INHALER (MDI)** ☐ **EPINEPHERINE AUTO-INJECTOR** ☐

_____ (physician's initials) For severe breathing difficulty, emergency asthma medication (specify) _____

inhaled dose: 2 puffs ☐ 4 puffs ☐ ampule may be repeated _____ times _____ minutes apart.

_____

(Physician's Signature) (Printed Name) (Date) (Phone)