Epi Pen Medication Form

Campbell Independent School District
409 W. North St.
Campbell, Texas 75422
Phone: 903.862.3250 x 217
fax: 903.862.3546

Request for Administration of Medication at School

Requests for the administration of medication by school personnel may be as follows:

1. When such medication cannot be given outside of the school day.
2. **Prescription medications require a physicians' request to continue to be taken at school when the medication needs to be taken beyond a 10-day period of time** (May not take more than 3 consecutive days unless evidence of medical care.) (FFAC-Local)
3. Medication must be in the original container properly labeled by the pharmacist filling the prescription, or labeled by the manufacturing Drug Company if the medication is available over the counter. (OTC label to include indications, dosage and warnings/contraindications) (Texas Education Code 21.914)
4. **The School Health Office must have a parent authorization on file before school personnel may assist with administration of medications.**

Medically untrained personnel will administer medications at those times when the Nurse if unavailable.

Student's name: ______________________________ **Date of Birth:** __________

Condition for which medication(s) is required: ______________________________

1. **Medication** ______________________ Dosage ________________
   Additional directions: (time of day, any special requirements in regard to food, interval between doses, etc.)
   ____

   Precautions, side effects, and unfavorable reactions: ______________________________

I, the parent/guardian of ______________________________ request the above medication(s) be administered to the above named student. The School Nurse has my permission to contact my child's health care provider for information/clarification of a medication order or the condition requiring medication.
I give my consent for the release and exchange of information contained in the medical record of my childe (named above).

My child has permission to carry the prescribed Epi-Pen on his/her person: Yes ________ **No** ________

Parent/Guardian Signature ______________________________ **Date:** ________________

Please give ______________________________ **the above medication(s) as ordered and/or directed**

The above named student has a medical need to carry the prescribed Epi-Pen on his/her person and is competent to self-medicate this medication.

Yes __________ **No** __________

Physician Signature: ______________________________ **Date:** ______________

Printed name of Physician: ______________________________ **Phone:** ______________

FAX: ______________