ROCKWALL ISD
HEALTH SERVICES

Medication Orders/Authorization/Consent

Student's Name: _____ **DOB:** _____ **Student ID#**_____

Allergies: _____ **School:** _____ **Teacher/Grade:** _____

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

MEDICATION	DOSE/ ROUTE	START DATE	END DATE	FREQUENCY/ TIME OF ADMINISTRATION	FIRST DOSE OF NEW MEDICATION?	*MAY GIVE MORNING DOSE
					☐Yes ☐No	
					☐Yes ☐No	
					☐Yes ☐No	
					☐Yes ☐No	
					☐Yes ☐No	

***Initial box above to indicate: Student may take morning dose of medication, if forgotten at home, with telephone permission from parent.**

_____ _____ _____
(Physician Signature) **(Print Name)** **(Date)**

_____ _____ _____
(Office Address) **(Office Phone)** **(Fax)**

·Valid for one school year. Whenever possible, medication should be given outside of school hours.
·Physician signature is **required** for all over-the-counter (OTC) medications, medication samples, and off-label prescription medications.
·Prescription medication must be in the pharmacy container with a current prescription label.
·OTC medication must be in the original, labeled container and not expired.
·Herbal substances, dietary supplements, homeopathic or alternative medications are not tested by the US Food and Drug Administration for safety or effectiveness. Lack of safety information limits their appropriate use at school. These medications will not be administered unless it has been determined educationally necessary as part of a student's individualized education plan or Section 504 plan.

_____ **Changes in medication or dosage require a new physician signature/order. Any new or additional medication requests require a new form to be completed.**
Parent Initials

_____ **Unused medication must be picked up by the parent at the end of the school year or within 5 days after discontinued. Medications not picked up will be disposed of.**
Parent Initials

I request and authorize Rockwall ISD to administer the above medication(s) as prescribed. I understand that the school administrator may designate any qualified employee to administer this medication. I authorize the school registered nurse and the prescribing physician to confidentially discuss or clarify this medication order, and to discuss the student's response to the medication as required by law (Nurse Practice and Medical Practice Acts of Texas).

_____ _____ _____
(Parent/Guardian Signature) **(Print Name)** **(Date)**

_____ _____
(Day Phone Number) **(Email)**

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Reasons Dose Not Given						*comments/notes needed
A	FT	H	R	ED	OOM	Waste
Absent	Field Trip	Hold*	Refused*	Early Dismissal	Out of Medication	Waste*

Medication Administration Record

Document doses administered by staff who are not Skyward Health Records users and wasted meds

Date	Time	Medication	Quantity administered/ route	Reason not given	Notes/comments	Admin by (signature)

Receive/Return Medication

Document witnessed pill count of all controlled medications received, returned to parent, or intra-district transfer to new campus (count at both sending and receiving campus). Witness: parent or RISD staff.

DATE	MEDICATION	DOSAGE	AMOUNT RECEIVED	AMOUNT RETURNED	EXPIRATION DATE	SIGNATURE	WITNESS SIGNATURE