Mathis ISD Health Service	**Medication Administration Consent** (*page 1 of 2*)

Only medications that are required to enable a student to stay in school may be given at school. Three times a day medication should be given before school, after school, and at bedtime. If necessary, medication can be given at school under the following conditions:

1. **PRESCRIPTION MEDICATION FILLED DATE MUST BE WITHIN 30 DAYS OF CURRENT DATE.** All medications must be provided to school by an adult.
2. **MEDICATION SENT IN BAGS OR UNLABELED CONTAINERS WILL NOT BE GIVEN AND WILL BE DESTROYED.** Non-prescription OTC medication must be in a new unopened container with the manufacturer's original label. Physician samples must be appropriately labeled by the physician with the patient's name and instructions. Medications must be age appropriate.
3. **The first day dosage of any medication must have been given at home before it can be administered at school.**
4. Written order from a healthcare provider indicating student is allowed to carry and self-administer EpiPen / Inhaler / Insulin is required.
5. Action Plan submitted □ No □ Yes Date_____Initials_____
6. FDA approved OTC medication may not be given longer than 7 consecutive days without a doctor's written prescription.

MEDICATION ADMINISTRATION

STUDENT:_____**DOB:** ___/___/_____**GRADE:**_____**SCHOOL YEAR:** **2024-2025**

Any Known Allergies □ No □ Yes_____ **Possible Side effects**_____

MEDICATION	DOSE	Route	TIME GIVEN	START - END DATE	Reason for Medication

Special storage instructions □ No □ Yes _____

Special requirement for administration □ No □ Yes_____

PARENT / GUARDIAN CONSENT

- I give my permission for the above medication to be administered to my child at school or on school sponsored field trips according to the above requirements.
- I give my permission for my child to self-carry/self-administer emergency medication.
- I understand that the medication may be given by an authorized MISD employee in the absence of the nurse/assistant.
- I understand that medication will be destroyed if not picked up by the end of the last day of school.
- I give permission for my child to transport the above medication home. I accept responsibility for my child and the specified medication. I understand controlled medication will not be sent home with students.
- I authorize the school nurse/assistant to communicate with our health care provider as allowed by HIPPA. PROVIDER _____Phone # _____
- I authorize the school to disclose the above information to those within the school district that have a need to know for educational purposes.

Parent / Guardian Name _____Signature_____Date_____

Relationship:_____ Phone#_____Work#_____

	Mathis ISD Health Service	**Medication Administration Consent** (p*age 2 of 2)*

DATE	MEDICATION QUANTITY	PARENT / GUARDIAN SIGNATURE	NURSE / ASSISTANT SIGNATURE	COMMENTS

DATE MEDICATION RETURNED TO PARENT/GUARDIAN OR STUDENT:
QUANTITY:
Parent/guardian or student signature:
Nurse/assistant signature:
MEDICATION WASTED (DISPOSED) DATE:
QUANTITY:
Nurse/Assistant Signature:
Witness Signature:

DATE ENTERED IN SKYWARD	DATE TEACHER NOTIFIED	COMMENTS

DATE REVIEWED BY RN	RN NAME /SIGNATURE / INITIALS