COLLEGE STATION ISD
PRESCRIPTION MEDICATION AUTHORIZATION FORM

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. All prescription medication must be provided in a container with the pharmacist's label attached. Physician samples must be appropriately labeled by the physician with the patient's name and instructions. MEDICATION SENT IN BAGGIES/UNLABELED CONTAINERS WILL NOT BE GIVEN AND WILL BE DESTROYED.
2. **The first dose of any medication must be given at home before it can be administered at school.**
3. An emergency plan for anaphylaxis and asthma + parental permission is required (separate form) for self-carry/self-administered emergency medications such as inhalers/EpiPens/insulin.

MEDICATION ADMINISTRATION AT SCHOOL

Student ____ Date __________ Grade __________ School Year ___________

Known Allergies: ____

(Use one form per medication. Form is valid for the current school year, including summer session)

Physician Name (Printed)	Phone number	Address	Physician Signature	Date
Medication	Dose	Time to be given	Start/End date	Comments

PARENT/GUARDIAN CONSENT:

- I give my permission for the above medication(s) to be given to my child at school or on school sponsored field trips according to the above requirements.
- I understand that the medication may be given by an authorized CSISD employee in the absence of the campus Registered Nurse.
- I understand that the medication will be destroyed unless picked up by the end of the last day of classes.
- I give permission for my child to transport the above medication(s) home. I accept responsibility for my child and the specified medication. I understand controlled medication will not be sent home with the student.
- I authorize the school nurse to communicate with our health care provider ______________________ as allowed by HIPAA.
- 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 signature   Date   Relationship to student

____

Home Phone Number   Work Phone Number   Cell Phone Number

FOR CLINIC USE ONLY:	× Entered in eSchool	× Teacher notified ______/______	× IHP (if applicable)

Prescription Medication Count:

Date	Count	Nurse signature	Parent/Witness signature	Date	Count	Nurse Signature	Parent/Witness signature

Comments:

Date	Comment	Date	Comment

Date Medication Returned to Parent or Student:
Medication:
Medication:
Parent or Student Signature:
Nurse Signature:
Medication Wasted (Disposed) on Date:
Medication and Quantity:
Medication and Quantity:
Nurse Signature:
Witness Signature:

Date Reviewed:	**RN Printed Name**	**RN Signature/Initials**