SOUTH SAN ANTONIO INDEPENDENT SCHOOL DISTRICT

DEPARTMENT OF STUDENT HEALTH SERVICES

LONG TERM
PERMISSION REQUEST FORM

When your student's physician determines it is necessary to administer medication during the school day, the following procedures must be followed:

1) A parent/ guardian or responsible adult designee must bring the medication to school and give to school nurse.
2) All medication must be in the **PRESCRIPTION/ORIGINAL CONTAINER** clearly labeled with the student's name, the name and dose of medication, directions for administration and date, pharmacy and physician name.
3) Long Term Permission Request Form must be completed by the physician each school year and when there is a medication and or dose change. Prescribing physicians must be licensed to practice in the state of Texas.
4) Only FDA approved pharmaceuticals manufactured in the United States will be administered.
   HOMEOPATHIC PREPARATIONS WILL NOT BE ACCEPTED.
5) **MEDICATIONS WILL NOT BE SENT HOME WITH STUDENTS**. All medication must be picked up by a parent/guardian or adult designee.
6) **Daily medication will be given at home.**
7) **Medication ordered 2 times a day can be given at home before school and when the child returns home from school.**
8) **If the medication is ordered 3times a day it can be give before school when the child returns from school and at bed time.**
9) **Medications ordered 4 times a day one dose will be given to the student at school at noon.**

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TO BE COMPLETED BY PHYSICIAN

Name of student____ Date of Birth ________________________

Medication	Dosage	Time of Administration	Duration of Treatment
________________	__________	_____________________	________________________
________________	__________	_____________________	________________________
________________	__________	_____________________	________________________

Medications administered at home: ____

The following emergency measure may be required at school: ____

____

Anticipated significant medication side-efforts, or other important precautions include: _________________________

____

The following restrictions on physical activity are required: ____

____until the following date _________________

________________________________ ___ ____

Printed name of physician **Signature of physician**

Telephone_______________________**FAX**____________________**Date**_______________________________

I give permission for my child to receive the above medication(s):

________________________ _______________________ ________________________

Parent/Guardian Signature **Telephone Number** **Date**