Cypress-Fairbanks Independent School District
Medication Authorization Form

Student Name _____ **Date of Birth** _____

Student ID# _____ **Campus** _____ **Grade** _____ **School Year 20____-20_____**

This form must be filled out completely in order for school health staff to administer any medication to a student. This form is to be completed and signed by the licensed Healthcare Provider. A new medication authorization form must be completed at the beginning of each school year for each medication, and each time there is a change in the medication's administration instructions.

In compliance with CFSID Board policy FFAC (local), all medications administered by CFISD staff must be:

- prescribed by a medical professional licensed with prescriptive authority in the state of Texas
- supplied in the original container (prescription bottle with prescription label or unexpired, unopened container with manufacturer's packaging) and will only be administered in accordance with prescriber guidelines,
- US FDA approved for safety and efficacy (school nurse must verify using reputable, peer-reviewed, evidence-based medical literature and may decline administration if she/he finds the dose to exceed current best practice or the medication is otherwise potentially harmful to the recipient),
- and retrieved from the clinic by a parent/guardian or his/her designee (responsible adult) by the last calendar day of the current school year or the medication will be destroyed in accordance with District expectations.

Medication Name and Strength: *(Number of mg/mcg etc.):*				**Medication Dosage:** *(Amount to Be Given)*	
Time to Be Given:	☐ **Breakfast**	☐ **Lunch**	☐ **PRN/ As Needed**	☐ _____ **(Specific time)**	☐ **Missed AM home dose** *(if verified by parent)*
Period of Administration:		☐ **30 days**	☐ _____**days**	☐ **Duration of school year**	☐ **As needed for emergency**
Route of Administration		☐ **Oral**	☐ **Inhaled**	☐ **Nasal**	☐ _____
Reason for Medication:					

TO BE COMPLETED BY HEALTHCARE PROVIDER			
HCP Printed Name and Title:		**Phone:**	
HCP Signature:		**Date:**	

I (parent/legal guardian) authorize school personnel to administer the above medication during school hours. I authorize the school's registered nurse or her designee to contact the prescribing physician regarding any clarifications needed regarding the medication listed above as required to assure safe administration. I understand if the circumstances are questionable, the school employee reserves the right to deny my request while investigating. I have reviewed this form; all of the information is accurate.

TO BE COMPLETED BY PARENT / LEGAL GAURDIAN			
Parent/ Legal Guardian Printed Name:		**Phone:**	
Signature:		**Date:**	

All unclaimed medication will be disposed of on the last day of school as required by law.

CFISD CLINIC USE ONLY

End of year disposition of medication:
- ☐ Retrieved by parent/guardian
- ☐ Destroyed by CFISD staff

No HCP signature on form due to:
- ☐ District approved medication
- ☐ Written order provided

Sign/Date: _____

Cypress-Fairbanks Independent School District

Controlled Substance Receipt/Release Log

Student Name: _____ School year: 20____ /____

Student ID#: _____ Medication name: _____

Date (Month/Day)	Medication Strength	Receipt/Release	Tablet Count (or ml)	H.S. Staff initials	P/G Initials
/		Receipt / Release			
/		Receipt / Release			
/		Receipt / Release			
/		Receipt / Release			
/		Receipt / Release			
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/		Receipt / Release			
/		Receipt / Release			

Initials: _____ Printed Name: _____

Initials: _____ Printed Name: _____

Initials: _____ Printed Name: _____

Initials: _____ Printed Name: _____

Revised 1/2024