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 initial dose of any medication new to the student must be given at home to observe for adverse reactions 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	Indications

*If an Action Plan signed by a physician is provided, attach a copy to this page in lieu of this physician signature.

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**