

## NON-PRESCRIPTION MEDICATION AUTHORIZATION FORM

*Note: This form should not be used for diabetes, seizure, asthma, or anaphylaxis medications.*

1. Non-prescription or over-the-counter medication (including cough drops) must be brought in by an adult in the original (unopened) container with the label intact and non-expired.
2. All medications need a physician signature and a parent/guardian signature. Any change in dosing will require a new order accompanied by physician signature and parent/guardian signature. No medication will be given without a parent/guardian and physician signature.
3. Medication prescribed or requested to be given three times a day or less will not be given at school unless a specific time of administration during school hours is prescribed by a physician.
4. 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.
5. 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 conditions listed on the following page.





### NON-PRESCRIPTION MEDICATION ADMINISTRATION AT SCHOOL

Student Name	
Date	
Grade	
School Year*	
Known Allergies	

*\*This form is valid for the current school year, including summer session*

Medication Name	
Dosage	
Route	
Time to be given/time interval	
Indications	

Physician Name (printed)	
Street Address	
City, State, Zip	
Phone	

\_\_\_\_\_  
Physician Signature\*

\_\_\_\_\_  
Date

*\*If orders for non-prescription medication use are included on an Action Plan signed by a physician, attach a copy of the Action Plan to this page in lieu of this physician signature*



### PARENT/GUARDIAN CONSENT

1. I request that designated personnel of YES Prep administer the medication listed to my child according to physician instructions.
2. I understand that YES Prep personnel will not administer medication if this form is not completed or the medication is not furnished as required.
3. I understand that the Board, the School District, and its employees shall be immune from civil liability due to allergic reactions or other injuries resulting from the administration of medication to my child, provided such administration conforms to the requirement of this policy.
4. I understand that the Nursing Practice Act and Texas Administrative Code §217.11 (D)(vi)<sup>1</sup> compels the RN or LVN to contact other health care team members, including the prescribing physician, concerning significant events regarding the patient's status.

**CHECK ONE:**

- I will pick up medication at the end of the year.
- Please dispose of medication at the end of the year.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to student

Home Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

<sup>1</sup> In accordance with the Nurse Practice Act; Texas Administrative Code, Section 217.11, the Registered Nurse and the Licensed Vocational Nurse have the responsibility and authority to refuse to administer medications that, in the nurse's judgment, are contraindicated for administration to the student.



FOR CLINIC USE ONLY

MEDICATION COUNT

Date	Count	Nurse Signature	Parent/Witness Signature

COMMENTS

Date	Comments

Date Reviewed	RN Printed Name	RN Signature/Initials