TARKINGTON ISD
HEALTH SERVICES

Authorization and Permission for Administration of Medication

Student's Name_____ **DOB**_____

(1) Parent signature and physician's order is required for the administration of any medication.
(2) Prescription and non-prescription medication must be in the original container and not expired..
(3) Changes in administration of medications, to include dose and time, must be in writing from the physician.
(4) The school will not give the first dose of any medication. All first doses of medication must be given at home, so the parent can monitor for side effects or adverse reactions.
(5) Prescription label must contain the patient name, name of the medication, directions for use & date.
(6) Physician orders for medications are only valid for the current school year.
(7) Medication left in the clinic after the last day of school will be destroyed.
(8) All medication must be brought to/from the clinic by the parent/guardian or authorized adult.
(9) Any emergency medication (i.e. Inhaler, Epi-pen, Glucagon, etc…) that is to be carried by the student, **must have the prescribing physician's approval.**

Physician Order for School Administration of Medication

Medication	**Dosage**	**Time**	**Qty provided (if applicable)**

Start Date_____ End Date_____ Allergies_____

Special Instructions_____

Condition(s) for which medication is to be given_____

Medications currently taken at home_____

Physician's Phone number_____ Fax number_____

Healthcare Provider:

My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I have verified the student's knowledge and skill to safely possess and use this medication, as required by law.

☐ **Student may self-carry emergency medication** ☐ **Student may self-administer emergency medication**

Physician's name (print)_____ **Signature**_____ **Date**_____

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and will pick up remaining medication and equipment on or before the last day of school or it will be properly destroyed.

Parent's Signature _____ **Date** _____ **Phone** _____

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