Medication Administration Form

Student's Name_____ DOB_____Grade_____Teacher _____

All medication should be given outside of school hours, if possible. Only medication that is required to enable a student to stay in school may be given at school. Medications ordered three times a day can be given before school, after school, and at bedtime. The initial dose of medication must be administered at home, doctor's office, or hospital. If medication is to be administered at school, the following conditions must be met.

- All medication (prescription and over-the-counter) must be:
  - provided by the parent or guardian.
  - All medications must be transported by parent/guardian. Controlled medications will be counted upon arrival in the clinic.
  - in its original properly labeled container. The pharmacy can supply two (2) labeled bottles for this purpose.
  - accompanied by a written request signed by the parent or guardian to give the medicine.
  - placed in a locked cabinet in a secure HISD district building (exception for asthma inhalers, epinephrine and some other emergency medications).
  - administered by a district employee (with the exception of our students that are authorized to self carry medication).
  - picked up at the health clinic by parent or legal guardian by the end of the school year. Otherwise it will be destroyed.

Start Date	**Name of Medication**	**Route**	**Strength** (i.e. 10mg)	**Dosage** (i.e.2tabs/1 tsp)	**Time to be Given**

Condition for which medication is required:	
Specific Instructions/Precautions:	

ALL medications including "over the counter" medicines require an authorization signed by a medical provider, and a parent/ guardian.

PARENT/GUARDIAN

I give permission for the above medication(s) to be administered to my child at school. As long as a physician authorizes a refill of any prescription set forth above, this authorization shall apply to any such refills. I understand that the District, the Board, and its employees are not liable for damages or injuries resulting from administration of medication to my child in accordance with Texas Education Code 22.052. I authorize the doctor above to release information regarding my student to the school nurse in Hutto ISD to facilitate my child's health and safety. Furthermore, I authorize the school nurse or other Hutto ISD personnel to communicate with my child's medical provider as necessary.

Parent/Guardian Signature_____**Relationship**_____**Date** _____

Home Phone_____Work Phone_____Cell Phone _____

PHYSICIAN

Physician Signature _____ Date: _____

Physician Name_____ Office phone_____ Fax_____

Student Withdrawal/prescription ended: Date_____Parent/Guardian signature_____

FOR HISD STAFF USE ONLY

Student Name:	DOB:	Grade/Teacher:
Medication:		Exp Date:
Dose:	Route:	Time:

Trained Staff Name:	Signature:	Initials:	Date:

Date	# of Pills	Received by Name:	Received by Signature:	Witnessed by:	Witness Signature:

Medication Picked up:

Date	# Pills/ML	Pick Up Name:	Picked up Signature:	Released by Name:	Released by Signature:

Medication Disposal:

Date	# Pills/ML	Disposed by Name	Disposed by Signature	Witnessed by Name	Witnessed by Signature