

**Waller Independent School District
AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION**

SCHOOL YEAR: 20 /20	
Student Name:	Birthdate
Student ID:	Grade:

This form must be filled out completely for school staff to administer any medication to a student. This form is to be completed and signed by a licensed healthcare provider. A new medication authorization form must be completed at the beginning of each school year for each medication as well as each time there is any change to the medication administration instructions.

In compliance with Waller ISD Board Policy and Texas Law, medication may be administered to a student by school personnel only after the following requirements are met:

1. All medications must be accompanied by a written request signed and dated by the prescribing physician (must have prescriptive authority in the state of Texas) and signed by the parent/guardian.
2. All prescription medication must be in the original pharmacy container or packaging and have a current prescription label.
3. All non-prescription medication must be in the original, unopened and unexpired packaging from the manufacturer.
4. Physician orders for medication are valid only for the current school year.
5. In accordance with the Texas Nurse Practice Act, Rule 217.11, the school nurse has the responsibility and authority to clarify any medication order with the prescribing practitioner and/or refuse to administer medication that, in the nurse's judgment, is not in the best interest of the student.
6. Students may not be in possession of any medications during school hours or any school related activities, on or off campus. Exceptions must be approved by appropriate school authorities in advance.
7. Natural and/or homeopathic-like products, essential oils, and any products that are not FDA approved will not be dispensed by school personnel. Medications from foreign countries will not be accepted or administered.
8. Discontinuance of medication must be in writing from the parent/guardian and/or physician.

PHYSICIAN/HEALTH CARE PROVIDER	
Name of Medication:	Dose to be Given:
Time to be Given at School:	Route of Administration:
Reason for Medication:	
Physician/HCP Printed Name:	Date:
Physician/HCP Signature:	Phone #:

PARENT/GUARDIAN	
<p>My signature authorizes the above-named student to be given the medication at school by qualified staff, according to the 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 regarding this medication, 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.</p> <p>All medications should be delivered to and picked up from the clinic by a parent or authorized adult. Any unclaimed medications will be disposed of on the last day of the current school year as required by law.</p>	
Parent/Guardian Printed Name:	Date:
Parent/Guardian Signature:	Phone #:

WISD CLNIC USE ONLY	
Date Medication Received:	
Clinic Staff Name:	

