



MEDICATION ADMINISTRATION AUTHORIZATION FORM

Student Name: _____ Date of Birth: _____
Medication Allergies: _____

Only those FDA approved medications that are medically necessary during school hours to enable a student to stay in school may be administered under the following conditions;

All Medications: Prescription & Non-Prescription

- Must be provided by the parent/legal guardian.
• Requires authorization dated for the current school year that is signed by the parent/legal guardian and a medical practitioner with authority to write prescriptions in the State of Texas (a current prescription label can serve as the physician's signature).
• Must be in the original container, properly labeled, and not expired.
• The first dose should be given at home to monitor for potential side effects.
• Changes in medication or dosage require a new authorization form.
• Must be stored in the clinic unless written authorization (below) is provided to self-carry and administer a rescue inhaler, epinephrine, or diabetic insulin and supplies.
• Must be picked up by the last day of school or will be disposed of, as required by law.

Table with 7 columns: Medication Name, Start Date, Stop Date, Dose, Route (how is it taken), Time(s) to be given at school, Diagnosis/Reason for medication

Medical Practitioner's Printed Name _____ Phone Number _____
Medical Practitioner's Signature _____ Date _____

MEDICAL PRACTITIONER AUTHORIZATION FOR SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION: I have instructed the above-named student, and they have demonstrated the ability to properly self-carry and self-administer their rescue inhaler and/or epinephrine delivery device and/or diabetic insulin and supplies.
Inhaler Epinephrine Delivery Device Diabetic Insulin and supplies
Parent/Legal Guardian Signature _____ Date _____
Medical Practitioner's Signature _____ Date _____

PARENT/LEGAL GUARDIAN AUTHORIZATION: I request authorized Keller ISD staff to administer the medication(s) specified to my child during school hours or on school sponsored field trips according to the instructions above. I give my permission to Keller ISD staff to contact the medical practitioner for additional information, if needed.
Parent/Legal Guardian Printed Name _____ Phone Number _____
Parent/Legal Guardian Signature _____ Date _____

HIGH SCHOOL STUDENTS ONLY - PARENT/LEGAL GUARDIAN AUTHORIZATION: I give permission for my child to bring home their medication (other than controlled substance) at the end of the school year.
Parent/Legal Guardian Signature _____ Date _____