



Medication Authorization Form

Name of School: _____

School Year: _____

The school nurse or other trained non-licensed personnel may administer medication when such treatment is necessary for school attendance. All medications, given three times per day or less, should be given outside school hours. Medication will be administered at school under the following conditions:

All Medications: Prescription & Non-Prescription

- Will be provided by the parent/guardian and require a parent/guardian written request and signature.
- Will be administered by the school nurse or other trained non-licensed employee designated by the superintendent designee
- Must be in the original container, be properly labeled, dated for the current school year and not expired.
- Will be stored in the clinic unless written authorization is provided (below) to self- carry an inhaler or epi-pen
- Must be picked up from the clinic by the last day of school. All remaining medication will be destroyed.

Prescription Medications:

- A written request by a physician or other healthcare professional with authority to write prescriptions in the state of Texas shall be required.
- The first dose should be given at home to monitor for any side effects.
- Prescription medication should be transported by an adult to and from school.
- Changes in medication or dosage require a new physician written order/signature and parent/guardian signature
- Only a 30-day supply will be accepted at a time.

Non-Prescription Medications:

- Only non-prescription medications from the district-approved list may be given without a physician's signature. These must be used on an "as needed" basis & for no more than five consecutive days. Dosing and administration must adhere to the instructions provided on the medication label. A physician's signature is required for anything outside of these guidelines.
- District-approved medications include Ibuprofen (Advil, Motrin), Acetaminophen (Tylenol), Diphenhydramine (Benadryl) and cough drops.

STUDENT INFORMATION

Name _____ DOB _____ Grade _____ Teacher/Advisor _____

MEDICATION/PHYSICIAN INFORMATION

Medication Name _____ Start Date _____

End Date: *order is good through
summer of current school year unless
otherwise specified.

Medication Dose _____ Route _____ Time or Frequency given at school _____

Diagnosis/Reason for Medication _____

*Student may take morning dose of medication, if forgotten at home, with telephone permission from parent: ☐ Yes ☐ No ☐ N/A

Physician Name (Please print) _____ Physician Phone Number _____

PHYSICIAN SIGNATURE _____ Date _____

PHYSICIAN AUTHORIZATION FOR EPI-PEN AND/OR INHALER TO BE CARRIED ON PERSON AND SELF-

ADMINSTERED In my opinion, it is necessary for the above named student to carry and self-administer their Epi-pen and/or rescue inhaler. Student has demonstrated ability to correctly administer medication and understands dosage and frequency. A back-up Epi-pen and/or inhaler should be supplied to clinic for emergencies. ☐ Epi-Pen ☐ Inhaler

Physician Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

PARENT AUTHORIZATION: My signature indicates that I request that MISD staff administer the medication specified to my child and I am giving permission for MISD staff to contact the physician for additional information, if needed.

PARENT/GUARDIAN SIGNATURE _____ Date _____

Staff Signature _____ Date Received in clinic _____ Revised 7/2025