Medication Orders/Authorization/Consent

Student's Name: _____ DOB:_____ Grade:_____

Condition for which medication is given, side effects for child, special instructions, pertinent information:

_____

Allergies:_____

MEDICATION	DOSE/ ROUTE	START DATE	END DATE	FREQUENCY/ TIME TO BE GIVEN	1ST DOSE OF NEW MEDICATION? *Circle one*
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No

- Parent-provided nonprescription medication may be given for 5 days with no physician signature. A physician signature will be required if medication is needed longer than 5 days
- All medications must be: unexpired, clearly labeled, and in the original, smallest container
- Physician signature is required for off-label medications, medication samples, and when clarification is needed for medication orders
- Herbal substances, dietary supplements, homeopathic or alternative medications lack safety information which limits their appropriate use at school. These medications will not be administered unless it has been determined educationally necessary as part of a student's IEP or 504 plan.

_____ (parent initials) **Changes in medication or dosage require a new physician signature/order. Any new or additional medication requests require a new form to be completed.**

_____ (parent initials) **Unused, discontinued or expired medication must be picked up by the parent. Medications not picked up will be disposed of at the end of the year or within 5 days after discontinued.**

I request and authorize Community ISD to administer the above medication(s). I understand that the school administrator may designate any qualified employee to administer this medication. I authorize the school licensed nurse and prescribing healthcare provider to confidentially discuss or clarify this medication order, and to discuss the student's response to the medication as required by law (Nurse Practice and Medical Practice Acts of Texas)

_____ _____ _____ _____

(Parent/Guardian Signature) (Print Name) (Date) (Phone)

PHYSICIAN/HEALTHCARE PROVIDER

I request and authorize the above medication(s), dosage and frequency.

_____ _____ _____ _____

(Physician Signature) (Print Name) (Date) (Phone)

HEALTH SERVICES
COMMUNITY ISD

Medication Orders/Authorization/Consent

Student's Name: _____ **DOB:** _____ **Grade:** _____

Medication Name: _____ **Dosage:** _____

Document witnessed pill count of all controlled medications received or returned to parent.

DATE	AMOUNT RECEIVED	AMOUNT RETURNED	TOTAL IN BOTTLE	WITNESS SIGNATURE	WITNESS SIGNATURE

Every Other Week Medication Inventory

WEEK OF	# IN BOTTLE	VARIANCE #	WITNESS INITIAL	WITNESS INITIAL		WEEK OF	# IN BOTTLE	VARIANCE #	WITNESS INITIAL	WITNESS INITIAL

Wasted Doses

DATE	REASON WASTED (DROPPED DOWN SINK, DROPPED ON FLOOR, ETC.)	WITNESS INITIAL	WITNESS INITIAL

_____ Witness Initial _____ Witness Name

_____ Witness Initial _____ Witness Name

_____ Witness Initial _____ Witness Name

_____ Witness Initial _____ Witness Name