

**Prescriber Authorization Form
Over-The-Counter (OTC) Medication**

Student Name: _____ **DOB:** _____ **ID#:** _____

In accordance with Iola Independent School District policy and the Texas State Board of Nursing licensing standards, the following procedure is required for administration of over-the-counter medication to a student by school personnel.

- A signed order from MD, DO, APRN, PA, dentist or podiatrist. At this time, licensed chiropractors are not included. A new signed order must be provided at the beginning of each school year, for each over-the-counter medication, and any time there is a change in medication administration instructions.
- Medications that are not FDA approved will not be administered unless prescribed by a physician and required by the IEP or Section 504 plan of a student with a disability. This includes but is not limited to herbal and dietary supplements.
- Medications ordered to be given three times a day or less will not be given at school unless a specific time of administration during school hours is prescribed by a physician.

**** TO BE COMPLETED BY PHYSICIAN ****

Medication Name:		Reason for Medication:	
Strength:	Dose:	Route:	
Administration Time:		Start Date:	End Date:
Drug Allergies:		Possible Side Effects:	
Special Instructions:			

Physician Name (printed): _____ **Phone number:** _____

Physician Signature: _____ **Date:** _____