SANGER INDEPENDENT SCHOOL DISTRICT
AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

The Texas State Law (Texas Education Code 22:052) requires physician/dentist/APRN or PA's written order **and** the parent/guardian's written authorization for a nurse to administer prescription medications or, in his/her absence, designated staff to administer medications. Medications must be in pharmacy-prepared containers and labeled with the student's name, name of drug, strength, dosage, frequency, provider, and date of original prescription. (When filling a prescription, please ask the pharmacist for a second bottle for school.) No first dose of any medicine will be administered at school for safety reasons. **Antibiotics will only be given at school if the order requires mid-day dosages.**

Physician/Dentist/NP/PA Order:

Student's Name_____Grade_____Date of Birth: _____
Condition for which this medication needs to be administered during school hours_____
Drug (name, dose, and method of administration)
_____
Time of administration _____Order Date Range:_____
Relevant side effects to be observed _____
Physician's Printed Name: _____Phone_____Fax_____

Physician's Signature: _____

Authorization by Parent/Guardian for the administration of the above medication by school personnel

I agree to hold harmless Sanger ISD, and its employees, for any consequences resulting from the administration of this medication/treatment. I request that the above medication, ordered by his/her medical provider for my child (named above), be administered by school personnel. I understand that I must supply the medication in the original containers; dispensed and properly labeled by a physician or pharmacist, and will provide no more than a 45 school day supply. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or a week beyond the close of school.
Printed Name: _____ Relationship to child: _____

Signature: _____ Date: _____Phone:_____

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SEPT																															
OCT																															
NOV																															
DEC																															
JAN																															
FEB																															
MAR																															
APR																															
MAY																															

JUN																														

Date medication received/notes and medication count- Please initial

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Signature/initials_____

Signature/initials_____

Signature/initials_____

Signature/initials_____