



Request for Administration of Medication by School Personnel

Medication will be administered at school only when necessary for attendance and cannot reasonably be scheduled outside school hours. Medication will be stored in the clinic unless the physician authorizes student self-carry of an emergency rescue medication. Parent-provided medication may be administered at school only when all requirements below are fully met.

- A completed medication authorization form signed by the **physician and parent/guardian is required** for all **prescription and over-the-counter medications**.
- Medication must be delivered by a parent/guardian in the original container. Prescription medication must have a current pharmacy label, and over-the-counter medication must be in the original unopened container. **The pharmacy label must match the written physician order exactly in medication, dose, route, and timing of school dose.**
- The first dose must be given at home.
- All medications must be FDA approved.
- Any medication change requires a new physician-signed authorization form before the change can be implemented at school.

Students attending multiple campuses who require as-needed medication must have medication supplied at each campus and *delivered by a parent/guardian*. JISD Nurses will not be responsible for transportation of students' personal medications.

This form does not apply to asthma, severe allergy, or diabetes action plans. Management plans for these conditions are available on the JISD website.

Unclaimed medication will be disposed of at the end of the school year. **Forms are valid for one school year only.**

Student Information:

Name Date of Birth Grade

Medication	Dose	Route	Time to Administer	Reason	Specific Administration Instructions

Prescribing Physician Printed Name

Date

Prescribing Physician Signature

Office phone number

Permission is granted for designated school personnel to administer these prescribed and /or parent-provided medication(s) to my child, as listed and approved by the prescribing physician. **My signature indicates that I am giving permission for JISD staff to contact the physician for additional information or clarification, if needed.*

Parent/Guardian Signature

Contact Number:

Date

Nurse Signature:

Date