



TARKINGTON ISD HEALTH SERVICES
Authorization and Permission for Administration of Medication

Students Name _____ DOB _____

General Guidelines

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| (1) Parent signature is required for the administration of any medication. | (5) Prescription label must contain the patient name, name of the medication, directions for use & date. |
| (2) Prescription and non-prescription medication must be in the original container. | (6) Physician orders for medications are only valid for the current school year. |
| (3) Changes in the administration of prescription medication, including dose and time, must be in writing from the physician. | (7) Medication left in the clinic after the last day of school will be discarded. |
| (4) Changes in the administration of non-prescription medication, to include discontinuance, must be in writing from the parent/guardian and/or physician. | (8) All medication must be brought to/from the clinic by the parent/guardian or authorized adult. |
| | (9) Any emergency medication (i.e. Inhaler, Epi-pen, Glucagon, etc...) that is to be carried by the student, must have the prescribing physician's approval. |

Parent/Guardian Permission for School Administration of Short-Term Medication

Parent authorization is valid for 5 days for over the counter and short-term prescription medication.

Medication	Dosage	Time	Qty provided (if applicable)
Start Date _____	End Date _____	Allergies _____	
Special Instructions _____			
Condition(s) for which medication is to be given _____			
Medications currently taken at home _____			

Physician Order for School Administration of Long-Term Medication

Medication needed for more than 5 days, PRN (as needed) prescription medication, non-prescription medication dose that exceeds recommended dosage on the container and emergency prescription medication, all require a physician's order.

Medication	Dosage	Time	Qty provided (if applicable)
Start Date _____	End Date _____	Allergies _____	
Special Instructions _____			
Condition(s) for which medication is to be given _____			
Medications currently taken at home _____			
Physician's Phone number _____		Fax number _____	

Healthcare Provider:

My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I have verified the student's knowledge and skill to safely possess and use this medication, as required by law.

☐ **Student may self-carry emergency medication** ☐ **Student may self-administer emergency medication**

Physician's name (print) _____ Signature _____ Date _____

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and will pick up remaining medication and equipment on or before the last day of school or it will be properly discarded.

Parent's Signature _____ Date _____ Phone _____