HUTTO ISD
HEALTH SERVICES

Student Name:_____ DOB:_____

All medication should be given outside of school hours, if possible. Only medication that is required to enable a student to stay in school may be given at school. Medications ordered three times a day can be given before school, after school, and at bedtime. The initial dose of medication must be administered at home, doctor's office, or hospital. If medication is to be administered at school, the following conditions must be met.

All ***prescribed medication*** must be:

- Provided by the parent or guardian
- Ordered by an authorized prescriber
- All medications must be transported by parent/guardian. Controlled medications will be counted upon arrival in the clinic.
- In its properly labeled container. The pharmacy can supply two (2) labeled bottles for this purpose ● Accompanied bv a written request signed by the parent or guardian to give the medicine.
- Placed in a locked cabinet in a secure HISD building (exception for asthma inhalers, epinephrine and some other emergency medications).
- Administered by an authorized district employee (with exception of our students that are authorized to self carry medication).
- Picked up at the health clinic by parent or legal guardian by the end of the school year. Otherwise it will be destroyed.

All ***over the counter medications*** must be:

- Accompanied by a written request to administer the medication from the parent, legal guardian, or other person having legal control of the student
- Unexpired and administered from a container that appears to be the original container and appropriately labeled.
- Administered consistently with the instructions on the container's label.

Start Date	Name of Medication	Route	Strength (i.e. 10mg)	Dosage (i.e.2tabs/1 tsp)	Time to be Given
Condition for which medication is required:					
Specific Instructions/Precautions:					

MEDICATION WITHOUT A PHYSICIAN ORDER WILL ONLY BE ADMINISTERED UP TO 5X/SCHOOL YEAR. AFTER 5TH DOSE -or- BASED ON CLINICAL JUDGEMENT , PARENT MUST PICK UP MEDICATION.		
1st Dose	**Date/Time:**	**Staff:**
2nd Dose	**Date/Time:**	**Staff:**
3rd Dose	**Date/Time:**	**Staff:**
4th Dose	**Date/Time:**	**Staff:**
5th Dose	**Date/Time:**	**Staff:**

Student Name:_____ DOB:_____

ALL prescribed medications require an authorization signed by a medical provider, and a parent/ guardian. ALL over the counter medications require an authorization signed by a parent/guardian. Administration of OTC medications by licensed personnel will be performed based on clinical judgement.

PARENT/GUARDIAN

I give permission for the above medication(s) to be administered to my child at school. As long as a physician authorizes a refill of any prescription set forth above, this authorization shall apply to any such refills. I understand that the District, the Board, and its employees are not liable for damages or injuries resulting from administration of medication to my child in accordance with Texas Education Code 22.052. I authorize the doctor above to release information regarding my student to the school nurse in Hutto ISD to facilitate my child's health and safety. Furthermore, I authorize the school nurse or other Hutto ISD personnel to communicate with my child's medical provider as necessary.

Parent/Guardian Name:	**Home/Cell Ph:**
Relationship to Student:	**Work Ph:**
Parent/Guardian Signature:	**Date:**

PHYSICIAN (*NOT REQUIRED FOR OVER THE COUNTER MEDICATIONS*)

Physician Name:	**Office Ph:**
Physician Signature	**Fax:**
	Date:

FOR HISD STAFF USE ONLY		
Student Name:	DOB:	Grade/Teacher:
Medication:		Exp Date:
Dose: Route:		Time:

Trained Staff Name:	Signature:	Initials:	Date:

FOR HISD STAFF USE ONLY	Student Name:_____ DOB:_____

Medication Received:

Date	# of Pills	Received by Name: Received by Signature:	Witnessed by:	Witness Signature:

Medication Picked up:

Date	# Pills/ML	Pick Up Name: Picked up Signature:	Released by Name:	Released by Signature:

Medication Disposal:

Date	# Pills/ML	Disposed by Name Disposed by Signature	Witnessed by Name	Witnessed by Signature

Student Withdrawal/Prescription Ended	
Parent/Guardian Signature:	**Date:**