

Cleburne ISD Health Services  
**Medication Administration Authorization Form**

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ School Year: \_\_\_\_\_  
CISD Campus: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**\*One medication order per medication form (Prescription and over-the-counter) written below by the Physician/PA/NP.**

| Medication Name | Medication Dosage/Route | Time of administration | Specific administration instructions |
|-----------------|-------------------------|------------------------|--------------------------------------|
|                 |                         |                        |                                      |

*\* Only FDA approved medications can be administered at school.*

**Physician/PA/NP Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **NPI#** \_\_\_\_\_

**Physician/PA/NP Name:** \_\_\_\_\_ **Office Phone:** \_\_\_\_\_

**\*\*** In accordance with the Nurse Practice Act, Texas Code Section 217.11, the school nurse has the responsibility and authority to clarify any medication order with the appropriate licensed practitioner and/or refuse to administer medication that in the nurse's judgment, is not in the best interest of the student.

| Print Name of Staff Receiving | Date Received | Medication Expiration | CISD Staff Signature |
|-------------------------------|---------------|-----------------------|----------------------|
|                               |               |                       |                      |

**Campus RN reviewed the above medication on \_\_\_\_\_ RN Signature \_\_\_\_\_**

I give permission, as the parent/guardian of the above student, for my student to receive the medication as ordered above by a physician/PA/NP at school according to the Medication Administration Protocol and board policy.

***By signing this form, I agree with the CISD Medication Protocol/Policy and release Cleburne ISD from any liability.***

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Parent/Guardian Name:** \_\_\_\_\_

**Primary Contact Phone for Parent/Guardian:** \_\_\_\_\_

Student Name: \_\_\_\_\_ Medication: \_\_\_\_\_

Monthly Reconciliation

| Month     | Date | Count Verified | RN Name | RN Initials |
|-----------|------|----------------|---------|-------------|
| August    |      |                |         |             |
| September |      |                |         |             |
| October   |      |                |         |             |
| November  |      |                |         |             |
| December  |      |                |         |             |
| January   |      |                |         |             |
| February  |      |                |         |             |
| March     |      |                |         |             |
| April     |      |                |         |             |
| May       |      |                |         |             |

Medication Inventory Sign-In/Out Log

| Date | Quantity Received | Expiration Date | Parent/Guardian Signature | Nurse/Office Signature |
|------|-------------------|-----------------|---------------------------|------------------------|
|      |                   |                 |                           |                        |
|      |                   |                 |                           |                        |
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