



Cypress-Fairbanks Independent School District

Medication Authorization Form

Student Name _____ Date of Birth _____

Student ID# _____ Campus _____ Grade _____ School Year 20____ - 20____

All medications require parent/guardian authorization upon intake to the school clinic. FDA approved prescription medication requires a prescriber's order within 10 days of receipt of medication by school staff. FDA approved non-prescription medication given in excess of recommended dosage on the container also requires a prescriber's order. A new medication authorization form must be completed at the beginning of the school year for every medication, and whenever there is a change in the medication's administration instructions.

In compliance with CFISD Board policy FFAC (local), all medications administered by CFISD staff must be:

- prescribed by a medical professional licensed with prescriptive authority in the state of Texas (unless US FDA approved medication available for purchase without a prescription),
- supplied in the original container (prescription bottle with prescription label or unexpired, unopened container with manufacturer's packaging) and will only be administered in accordance with prescriber guidelines,
- US FDA approved for safety and efficacy (school nurse must verify using reputable, peer-reviewed, evidence-based medical literature and may decline administration if she/he finds the dose to exceed current best practice or the medication is otherwise potentially harmful to the recipient),
- and retrieved from the clinic by a parent/guardian or his/her designee (responsible adult) by the last calendar day of the current school year or the medication will be destroyed in accordance with District expectations.

Medication Name and Strength: (number of mg/mcg etc.)				Medication Dosage: (amount to be given)	
Time to be Given:	☐ Breakfast	☐ Lunch	☐ PRN/ As needed	☐ _____(Specific time)	☐ Missed AM home dose
Period of Administration:	☐ 30 days	☐ _____ days	☐ Duration of school year	☐ As needed for emergency	
Route of Administration:	☐ Oral	☐ Inhaled	☐ Nasal	☐ _____	
Reason for Medication:					

TO BE COMPLETED BY HEALTHCARE PROVIDER

(Required for prescription medication or non-prescription medication requested to be given in excess of recommended dosage)

HCP Printed Name and Title:		Phone:	
HCP Signature:		Date:	

I (parent/legal guardian) authorize school personnel to administer the above medication during school hours. I authorize the school's registered nurse or her/his designee to contact the prescribing physician regarding any clarifications needed regarding the medication listed above as required to assure safe administration. I understand if the circumstances are questionable, the school employee reserves the right to deny my request while investigating. I have reviewed this form; all of the information is accurate.

TO BE COMPLETED BY PARENT / LEGAL GUARDIAN

Parent/Legal Guardian Printed Name:		Phone:	
Signature:		Date:	

All unclaimed medication will be disposed of on the last day of school as required by district policy.

CFISD CLINIC USE ONLY

End of year disposition of medication:

- ☐ Retrieved by parent/guardian
- ☐ Destroyed by CFISD staff

Summer School:

- ☐ Medication dropped off on _____
- ☐ Retrieved by parent/guardian
- ☐ Destroyed by CFISD staff

No HCP signature on form due to:

- ☐ Med administered <10 days
- ☐ Written order provided

Sign/Date: _____

Sign/Date: _____



Cypress-Fairbanks Independent School District

Controlled Substance Receipt/Release Log

Student Name: _____ School year: 20____ / ____

Student ID#: _____ Medication name: _____

Date (Month/Day)	Medication Strength	Receipt/Release	Tablet Count (or ml)	H.S. Staff initials	P/G Initials
/		Receipt / Release			
/		Receipt / Release			
/		Receipt / Release			
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/		Receipt / Release			

Initials: _____ Printed Name: _____

Initials: _____ Printed Name: _____

Initials: _____ Printed Name: _____

Initials: _____ Printed Name: _____