Trinity Independent School District

"Community Committed to Learning"

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

I request that _____School, through the School Nurse or designee supervise/assist in the administering of medication to my child, according to the instructions below. I understand that:

- All prescription medications and sample medications dispensed through a physician's office must be in their original pharmacy container (no baggies, foil, etc.) or packaging and labeled by the pharmacist or physician.
- Parent/guardian must provide specific instructions, as well as the medication and related equipment to the clinic personnel.
- All non-prescription medications must be in their original container. The written request for administration of these over-the counter medications, made by parent, guardian, or physician must contain all medication information below. All non-prescription medications given more than 10 consecutive days must have a physician's signature.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- Physician orders for medications are valid ONLY for the CURRENT school year.
- All medication will be taken directly to the office/clinic by the parent/legal guardian.
- All medications will be stored and dispensed in school clinic. There are exceptions for asthma and allergic reaction medications but MUST be approved by school nurse.

PARENT/GUARDIAN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student Name (Last) (First) (MI)			Date of Birth	
Grade	Teacher	Height	Weight(lbs)	School Year
Name of Medication				
Dosage	Time to be given	Amount of Medication Provided		
Reason for Medication				

PROVIDER AUTHORIZATION

All prescription medication, non-prescription medication given more than 10 school days, or non-prescription medication when dosage is more than dosage on container require a physician's order.

Name of Medication	Dosage	Route	Refrigerate ☐ YES ☐ NO
Medication Instructions		Start Date	End Date
Physician Name (print)		Phone Number	
Physician Signature		Date	

My signature authorizes the above-named student be given the medication at school by qualified staff, according to the 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 regarding this medication, 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 the safe delivery of medications and equipment and understand the instructions above.

Parent/Guardian Name(print)	**Parent/Guardian Signature**	Date
Cell phone	Home Phone	Work Phone

ONE MEDICATION PER SHEET

Trinity ISD Medication Administration Record (MAR) **Year:_____**

Name: _____ School: _____
Known Allergies: _____

	Medication/ Dosage/ Frequency/route	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																																	
September																																	
October																																	
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March																																	
April																																	
May																																	
June																																	

Initial	Signature	Notes:

Disposition Code: A-absent, **R**-refused**, F**-field trip**, NMA**-no medication available**, D**-discontinued**, C**-changed **X**-No school