Hays CISD Student Health Services

School: _____ School Phone: _____ Fax/Nurse: _____

Authorization for Medication Administration during the School Day by School Personnel 2020-2021 School Year

Student Name: _____ Birth Date: _____

Student ID: _____ Grade: _____ Gender: M / F Teacher: _____

Student's Physician: _____ Phone: _____ Fax: _____

Medication Allergies: ☐ No Known Drug Allergies ☐ Allergic to: _____

Medication requested to be given at school: _____

Has the child ever taken this medication before? ☐ Yes ☐ No (All first doses of medication must be administered at home)

Parent Authorization

I understand that all medication(s) must be in the original container and must be provided by the parent(s) or guardian(s). All medications must be kept in the nurse's office unless the student is cleared by both the physician and school nurse to self-carry. All narcotics/schedule medication must be kept in the nurse's office at all times. All medication will be administered according to the Medication Policy FFAC. First doses of medications shall not be given at school. No more than a 30 day supply of medications may be kept on campus.

I authorize the physician named below to release information regarding medication(s) my child will take during school hours, to Hays CISD Student Health Services. In addition, with my physician's permission, I agree my child may self-medicate (to include inhalers, epi-pens, diabetes care) at school. I give permission for photographs to be taken of my child to be used on the medication bottle and log.

I request that the designated personnel of Hays CISD administer medication to my child, named above, according to written physician's instructions and for the school nurse to exchange information with the physician regarding medication and health related issues. I understand it is my parental responsibility to furnish an adequate supply of this medication in the original and properly labeled container. I will notify the school immediately if the health status of my child changes, we change physicians, or the medication is changed or cancelled. I understand that school district personnel will protect my child by not administering the medication if this form is not complete or the prescribed medication is not provided.

Parent Printed Name: _____ Phone: _____

Parent Signature: _____ Date: _____

Physician Authorization

Please be sure to provide action plans for seizures, asthma, and severe allergies

Medication Allergies: ☐ NKDA ☐ Allergic to: _____

Medication: _____ Dose **(mg not tablets)**: _____ Route: _____

Time(s) to be administered at school: _____ Dates to be administered: _____ OR ☐ Entire School Year

If PRN, describe indication: _____ May repeat PRN dose after: _____

Condition for which the medication is required: _____

Special instructions or known side effects of medication: _____

I verify the above medication information is accurate and needs to be administered during school hours for the student listed.

Student is authorized to self-carry and self-medicate (inhalers, epi-pens, and diabetes care) ☐ Yes ☐ No

Physician Name: _____ Signature: _____ Date: _____

Med Verified by: _____ Date: _____ ☐ Entered into EMR