Hays CISD Student Health Services

School:

Address:

Phone :

Fax:

Please complete and Fax to:

Authorization for Medication Taken During the School Day 2018-2019

All medication(s) must be in the original container and must be provided by the parent or guardian. 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.

Over-The-Counter (OTC) medications are given according to instructions on the original label for up to 10 days with a parent written request. If the OTC medication is to be given for longer than 10 days or at a different dose than on the label a physician's order is required in addition to the parent written request. Prescription medications require both physician's order and parent written request.

Parent please complete the section below: School: _____ Grade:_____ Teacher: _____

Students Name: _____ Birth Date: _____ Gender: M F

Home Phone: _____ Emergency Phone: _____

Physician's Name: _____ Phone: _____ Physician's Fax: _____

Office Address: _____

I authorize the physician named above 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 the above school district 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/Guardian Signature: _____ Date: _____

Printed Name_____

Physicians please complete this section and return to the parent or by fax to the number at top.

Diagnosis for which medication is prescribed: _____

Name of medication: _____ Dosage: _____ Route: _____

Time of administration at school: _____

If asthma inhaler and no response to treatment can repeat: _____

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

Significant side effects: _____

Medication is to be administered for: _____ Months Semester: Fall Spring Full Year

Student is authorized to self-medicate (includes inhalers, epi-pens, diabetes): Y N

Physician Signature: _____ Date: _____