

AISD/Ascension Seton- School Health Services Medication Authorization Permit

Student Name: _____ **Birth Date:** _____ **Student ID#:** _____

School Name: _____ **Teacher:** _____ **Grade:** _____

Children's AISD Student Health Services and AISD require the following:

- **Only those medications that are medically necessary during school hours for a student's attendance or written in an IEP should be sent to school.**
- A U.S. medical practitioner's written order and parent or guardian consent dated for the **CURRENT** school year and signed by the parent, legal guardian or other person(s) having legal authority of the student **AND** the medical practitioners who is licensed to practice medicine in the United States/State of Texas.
- Medication in the original, properly labeled container from a registered pharmacist (name of the student, name of the medicine with strength, dosage and directions; route to be given, name of prescribing physician who is licensed in Texas, and current date.
- Non-prescription/Over-the-counter medications require the above (AISD Student Handbook, FFAC Local)
- Students **ARE NOT ALLOWED** to carry any medication prescribed or over the counter, or to self-administer the medication unless ordered by the U.S. licensed medical practitioner. By law the only medications with a medical order/parent permission that may be carried by a student is an asthma inhaler, EpiPen, and/or insulin/diabetes medication and supplies.

Please complete the following:

Medication Name and Strength: (only one medication per page)	Dosage:	Time(s) to be given at school:	How it is taken: (mouth, eye, ear, nose, tube, on the skin, etc.)	Reason/Medical Condition for which medication is given:	Medication Expiration Date:	Additional Comments:

Medication Start Date: _____ **Medication Stop Date:** _____ *Good for the current school year 20__/20__

Medical Provider's Name (printed)

Medical Provider's Signature

Date

Email/Phone Number/Fax

****Note: the first dose of any medication may NOT be given at school****

Has the student ever received this medication before? Yes ___ No ___

*Yes, Date and Time last dose given _____

_____ I request that the above medication be given during school hours as ordered by this student's physician.

I also request that the medication be given on field trips, as prescribed with adequate notification from me.

1. I release school personnel from liability in the event adverse reactions result from taking the medication.
2. I will notify the school of any change in the medication, (dosage change, time change, etc.).
3. I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action(s) of the medication.
4. I give permission for the school nurse to consult with the above student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by the medication.
5. I give permission for the medication to be given by trained school personnel as delegated by the Principal.

Parent/Guardian Printed Name: _____ Signature: _____

Relationship: _____ Phone Number: _____ Date: _____

Reviewed by RN: _____ SHA _____ may/ _____ may NOT administer this medication
 RN PRINTED Name: _____ RN Signature: _____
 *Parent/Guardian/MD notified: Date/Time _____