HEALTH SERVICES

MEDICATION AUTHORIZATION FORM

Student Last Name **First name** **Birthdate** **Grade Level**

This form must be filled out completely in order for school health staff to administer medication to a student. A new medication authorization form must be completed at the beginning of each school year, for each medication, and each time there is a change in the medication's administration instructions.

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

- Delivered to the clinic by a parent/guardian or his/her designee (responsible adult).
- Prescription medications must be in the original container and be properly labeled. The label must, include date prescribed, pharmacy name and address, the serial (prescription) number, student's name, prescriber name, directions for use, and any cautionary statements. It must be prescribed by a physician or dentist licensed to practice in the United States.
- Over the counter medication must be in the original manufacturer's packaging and will only be administered in accordance with manufacturer's guidelines that are age/weight appropriate for the student, unless otherwise prescribed by a physician.
- Medication not retrieved from the clinic by a parent/guardian or his/her designee (responsible adult) by the last calendar day of the current school year will be destroyed in accordance with KISD procedures.
- Over the counter medications may be administered for no longer than 2 weeks with parental approval. A physician's note will be required for any non-prescription medication needed for longer than two weeks.

Medication Name:				**Medication Unit (mg/mcg etc.):**	
Medication Dosage: *(Amount to Be Given?)*				**Special Instructions:**	
Time to Be Given:	❑ **Breakfast**	❐ **Lunch**	❐ **PRN/ As Needed**	❐ _____ **(Specific time)**	❐ **Missed AM home dose** *(if verified by parent)*
Period of Administration:		❐ **30 days**	❐ _____**days**	❐ **Duration of school year**	❐ **As needed for emergency**
Route of Administration		❐ **Oral**	❐ **Inhaled**	❐ **Nasal**	❐ _____
Reason for Medication:					
Possible Side Effects:					

I authorize school personnel to administer the above medication during school hours. I authorize the school's registered nurse or her 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.

TO BE COMPLETED BY PARENT/ LEGAL GUARDIAN		**TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER**	
Parent/ Legal Guardian Printed Name:		**HCP Printed Name:**	
Phone:	**Date:**	**Phone:**	
I have completed and reviewed this form; all of the information is accurate.		**Date:**	**Fax:**
Signature:		**HCP Signature:**	

Atty approved August 2021