Medication Administration Authorization Form

Student's Name: _____DOB_____School:_____Grade_____

Physician: _____Phone:_____ Fax: _____

According to the Texas Education Code and Uplift Education's policy, all medications administered at school must comply with the following guidelines:

1. **All medication(s)** must be in its original/properly labeled container with written request, to administer, from the parent/guardian. The medication must be FDA approved with dosage information clearly marked on the container.
2. Medications kept at school for greater than 3 consecutive days will require written authorization from a licensed physician.
3. Only medications that cannot be given at home will be given at school.
4. No more than a 30 day supply of medication(s) will be accepted at a time.
5. Medication that has expired or is not picked up by the parent will be properly destroyed.
6. Trained district employees may administer medication(s) when a nurse is not available.
7. Aspirin or products containing aspirin will not be given without a physician's order.
8. Medication(s) purchased in a foreign country will not be administered to scholars, unless the pharmacy is a U.S. FDA approved pharmacy.

******For student safety, all medications should be brought to the clinic by the parent/guardian.***

Medications	Dose	Route	Time	Possible Side Effects	Length of Time to be Administered
Please list all diagnosis for which the above medication(s) are prescribed?					

Will this be the first dose of a new medication for the scholar? _____ Yes _____ No

FOR THE PHYSICIAN

I authorize the medication(s) listed above to be kept at school and administered to the student as listed above.

_____ _____

Physician's Signature Date

FOR THE PARENT/GUARDIAN

I authorize that the above medication(s) be given to my child as directed. I hereby give permission to the school nurse to contact the prescribing physician with any questions related to the above medication(s) and diagnosis.

_____ _____

Signature of Parent/Guardian Date

FOR OFFICE USE ONLY

Med. count

Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May

Medication started: _____ Medication stopped: _____ Returned to parent/guardian: _____