Red Lick ISD Parent Request for Medication Administration by School Personnel

Name_____ DOB_____
Student ID#_____

*All medications must be in the original, current, properly labeled container with clear and legible instructions.
*All medications to be administered at school must be FDA approved. Supplements, herbals, vitamins, homeopathic, and other non-regulated substances will not be administered by the nurse.
*Medication not picked up by parent/guardian by end of school year, or within 14 days of being discontinued will be disposed of.
*Students are not permitted to transport medications to and from school. Medications must be delivered and collected by an adult.

Medication:_____
Dose (mg)_____ Route_____ Indications for use_____
Instructions:_____
_____

I request and authorize qualified Red Lick ISD employees to administer the above medication as prescribed. I authorize the school's nurse and prescribing physician to confidentially discuss or clarify this medication order, and the student's response to the medication as needed, as required by law (Nurse Practice and Medical Practice Acts of Texas). This form is valid for one school year.

Parent/Guardian Signature_____ Date_____

Physician/Healthcare Provider signature is required for the following:
*Over the counter medications given more than 10 school days
*Medication samples or off-label prescription requests.

Physician/HCP signature_____Date_____
Physician/HCP printed name_____

THIS SECTION FOR SELF ADMINISTRATION OF PRESCRIPTION MEDICATIONS
(anaphylaxis, asthma, seizure, diabetic meds only)

I have instructed the above named student in the proper way to use his/her medication. It is my professional opinion that he/she has demonstrated proficient use and understanding, and should be allowed to self-carry and self-administer the medication while on school property, or at school-related events.
Physician/HCP signature_____Date_____

Parent/Guardian Signature_____ Date_____