# NACOGDOCHES ISD HEALTH SERVICES
# AUTHORIZATION FOR STUDENT TO CARRY MEDICATION

**STUDENT NAME: _____ DATE OF BIRTH: _____**
**SCHOOL: _____ GRADE: _____**
**GENDER** (PLEASE CIRCLE) FEMALE MALE

**FOR COMPLETION BY HEALTH CARE PROVIDER:**

HCP NAME: _____
TELEPHONE NUMBER: _____ FAX NUMBER: _____

DIAGNOSIS: _____
NAME OF MEDICATION: _____
DOSE: _____

CHILD IS KNOWLEDGEABLE ABOUT HIS/HER MEDICATION ___YES ___NO
CHILD HAS DEMONSTRATED PROPER TECHNIQUE IN ADMINISTERING MEDICATION ___YES ___NO
MEDICINE IS ADMINISTERED DAILY ___YES ___NO
TIME: _____
MEDICINE IS ADMINISTERED WHEN NEEDED ___YES ___NO
INDICATIONS FOR USE: _____
_____
SIDE EFFECTS: _____
COMMENTS:
_____
_____

( ) I HAVE INSTRUCTED_____IN THE PROPER WAY TO USE HIS/HER INHALER. IT IS MY PROFESSIONAL OPINION THAT HE/SHE SHOULD BE ALLOWED TO CARRY AND USE THIS INHALER BY HIM/HERSELF.

( ) IT IS MY PROFESSIONAL OPINION THAT_____SHOULD NOT CARRY AND USE THIS INHALER BY HIM/HERSELF.

**HEALTH CARE PROVIDER SIGNATURE: _____**
**DATE**: _____

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I GIVE PERMISSION FOR MY CHILD TO CARRY HIS/HER PRESCRIBED MEDICATION AND TAKE IT ACCORDING TO HEALTH CARE PROVIDER'S ORDERS AND NISD POLICY.

**PARENT SIGNATURE: _____**
**DATE: _____ DAYTIME PHONE NUMBER: _____**