## Request for the Administration of Medication at School

(Use a separate authorization form for each medication)

Student's Last Name _____, First Name _____, M.I. _____

**Student Number** _____ Grade _____ Teacher _____ Date of Birth _____/_____/_____

Allergies _____

**Parental Consent**

I am the parent or guardian of _____. I give my permission for him/her to take the following prescribed medication while at _____ School. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medications. I hereby release Terrell ISD and its employees form any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the above licensed prescriber.

_____ Parent/Guardian Signature

_____ Daytime Phone

_____ Date

**MEDICATION AUTHORIZATION**

**(For Use By Licensed Prescriber ONLY)**

Relevant Diagnosis _____ Medication _____

Dates medication must be administered at school: ___ Short Term (List dates to be given _____)

___ Every day at school ___ Episodic/Emergency Events ONLY

Dosage (Amount) _____ Route _____ From _____ Time(s) of Day _____

A. Serious reactions can occur if the medication is not given as prescribed: ___ Yes ___ No

If yes, describe:

B. Serious reactions/adverse side effects from this medication may occur: ___ Yes ___ No

If yes, describe:

Action/Treatment for reactions: _____

Report to you: ___ Yes ___No (Drug information sheet may be attached)

Special Handling Instructions: ___ Refrigeration ___Keep out of sunlight ___ Other _____

**Asthmatic/Diabetic/Food Allergy ONLY**

This student is both capable and responsible for self-administering this medication

___ NO ___YES- Supervised ___YES- Unsupervised

This student may carry this medication: ___ YES ___NO

Licensed Prescriber's Name _____

Telephone Number _____ Emergency Number _____

Licensed Prescriber's Signature _____ Date _____