Student Name ________________________________ **DOB**_________ **Grade**______ **Teacher/Home Room**_________________

Decatur ISD Medication Administration Request Form

Guidelines for Administration of Medication at School.

All medications should be given outside of school hours, if possible. Only medication that is required to enable a student to stay in school may be given at school. Medications ordered three times a day can be given before school, after school, and at bedtime. The initial dose of medication must be administered at home, doctor's office, or hospital. If medication is to be administered at school, the follow conditions must be met:

1. All medication (prescription and over-the-counter) must be:
   a. Provided be the parent/guardian.
   b. Transported by an adult if it is a controlled substance, i.e. Ritalin. Controlled medications will be counted upon arrival in the clinic.
   c. In its original, properly labeled container. The pharmacy can supply 2 labeled bottles for this purpose.
   d. Accompanied by a written request signed by the parent/guardian to give the medicine.
   e. Placed in a locked cabinet in the clinic (exception for asthma inhalers if self administration form is completed).
   f. Ordered by a physician if it is to be given longer than 10 days or 10 doses whichever is longer.
   g. Administered by a district employee.
   h. Picked up at the health clinic by a parent or legal guardian by the end of the school year. Otherwise it will be destroyed.
2. Sample prescription and alternative medicine must be labeled with the child's name and accompanied by a signed physician's order. When ordered, alternative medicine must be accompanied by a patient information sheet listing its ingredients, actions, and side effects. <u>Dietary supplements and other nutritional aids not approved as medication by the FDA may not be dispensed by school personnel.</u>
3. The district can assume no responsibility for loss or negligent behavior when the student carries his/her conventional or alternative medication or dietary supplement without knowledge of the campus health coordinator. **Noncompliance may subject the student to disciplinary action.**
4. The campus health coordinator must be consulted for long term medication, any health care procedure, or monitoring.

Start Date	Name of Medication/Amount Provided	Strength (i.e. 10mg)	Dosage (i.e. 2tabs/1 tsp)	Time to be Given

Date/Time/Initials-Clinic Use Only:

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Start Date	Name of Medication/Amount Provided	Strength (i.e. 10mg)	Dosage (i.e. 2tabs/1 tsp)	Time to be Given

Date/Time/Initials-Clinic Use Only:

*Staff Signatures/Initials:*___________________________ ____________________________ _______________________________

Parent/Guardian:

I give permission for the above medications to be administered to my child at school. I understand that the District, the Board, and its employees are not liable for damages or injuries resulting from administration of medication to my child in accordance with Texas education Code 21.905.

Parent/Guardian Signature____________________________________Relationship_________________Date__________________

Home Phone_______________________ Work Phone_______________________ Cell Phone________________________________

Physician Signature____Phone ____________________________________