VVISD PERMISSION FOR MEDICATION ADMINISTRATION AT SCHOOL

Medication is to be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood by the parent that the medication will be dispensed by the principal or his/her designee in the absence of the school nurse. The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

LAST name:__________________________________**FIRST name**:__________________________________

Date of Birth:____/_____/________ **Sex:**_______________ **Grade Level**:_____________

1) **Medication Name:**____**Diagnosis/Reasoning**:________________________

   Dose:______________________________ **Route**: ☐Oral ☐Topical ☐Intranasal ☐Inhalation ☐Nebulizer ☐Rectal ☐Injection

   Time(s) to be given:____**Duration:**____________________________________

2) **Medication Name:**____**Diagnosis/Reasoning**:________________________

   Dose:______________________________ **Route**: ☐Oral ☐Topical ☐Intranasal ☐Inhalation ☐Nebulizer ☐Rectal ☐Injection

   Time(s) to be given:____**Duration:**____________________________________

3) **Medication Name:**____**Diagnosis/Reasoning**:________________________

   Dose:______________________________ **Route**: ☐Oral ☐Topical ☐Intranasal ☐Inhalation ☐Nebulizer ☐Rectal ☐Injection

   Time(s) to be given:____**Duration:**____________________________________

4) **Medication Name:**____**Diagnosis/Reasoning**:________________________

   Dose:______________________________ **Route**: ☐Oral ☐Topical ☐Intranasal ☐Inhalation ☐Nebulizer ☐Rectal ☐Injection

   Time(s) to be given:____**Duration:**____________________________________

Medications must be given exactly as printed on the prescription label or Physician's order. To request the School Nurse, or school personnel aiding her, to give alternatively would be going against physician's orders and school policy. Please bring an updated prescription or Physician's order when requesting an alternate dose/frequency. *If the medication is an over-the-counter medication with no verified diagnosis, physician's order or note….and is given more than 3 times in a week, please submit permission from a Doctor to have the school continue giving the medication (physician's signature line listed below for convenience).*

The School Nurse, or school personnel aiding her, has my permission to give my Student his or her medication(s) as described above.

Date:__________ **Parent or Guardian's Signature**:____

Physician's Signature:____
(If medically necessary. There is no need to provide a physician's signature if the medication is a prescription.)

Office Use – Reviewed ________
Follow Up Necessary ________