Health Services

Maud Independent School District

Prescription Medication Authorization Form

STUDENT NAME: ____ **Date of Birth:** _________________

GRADE: __________ **Known Medication Allergies:** ____

MEDICATION: ____

REASON FOR MEDICATION: ____

DOSAGE (amount to be given) / ROUTE: ____

TIME/FREQUENCY/CIRCUMSTANCE TO BE ADMINISTERED AT SCHOOL: __________________________

____

LENGTH OF TIME MEDICATION IS TO BE ADMINISTERED:

☐ Current School Year ☐ Other, specify: ____

MEDICAL PROVIDER AUTHORIZATION

**Physician signature is required when prescription medications are available/administered more than 5 consecutive school days.*

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Physician Signature Date

____

Physician Name (print) Phone Number Fax Number

PARENT AUTHORIZATION

I request school personnel to administer the stated medication to my child during the school day. I hereby release Maud I.S.D. and employees of Maud I.S.D. from any liability due to medication administration, allergic reactions, or adverse side effects of the drug. I understand that it is my responsibility to notify the school nurse in writing of any medication changes. I have read and understand Maud I.S.D.'s medication guidelines and policy. Furthermore, I consent and authorize the Maud I.S.D. nurse to communicate with the prescribing physician regarding my child's health condition and/or medication order as needed. This consent will remain in effect for the duration of the medication order.

____

Parent/Legal Guardian Signature Date

____

Daytime Phone Number Cell Phone Number Home Phone Number

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Emergency Contact Name Phone Number Additional Phone Number

School Office Use

Date Completed Form on File: ____________________________ *Date Medication Received:* _________________________

Maud I.S.D. Nurse Signature: ____