Health Services

Maud Independent School District

Nonprescription (over-the-counter) Medication Authorization Form

STUDENT NAME: _____ **Date of Birth:** _____

GRADE: _____ **Known Medication Allergies:** _____

MEDICATION: _____

DOSAGE (amount to be given) **/ ROUTE:** _____

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

_____

☐ Follow directions as listed on drug label.

☐ Special Instructions: _____

LENGTH OF TIME MEDICATION IS TO BE ADMINISTERED: _____

☐Current School Year ☐Other dates, specify: _____

MEDICAL PROVIDER AUTHORIZATION (if applicable)

**Physician signature is required to administer over-the counter medications for more than 5 consecutive school days.*

_____

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.

_____

Parent/Legal Guardian Signature Date

_____

Daytime Phone Number Cell Phone Number Home Phone Number

_____

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: _____