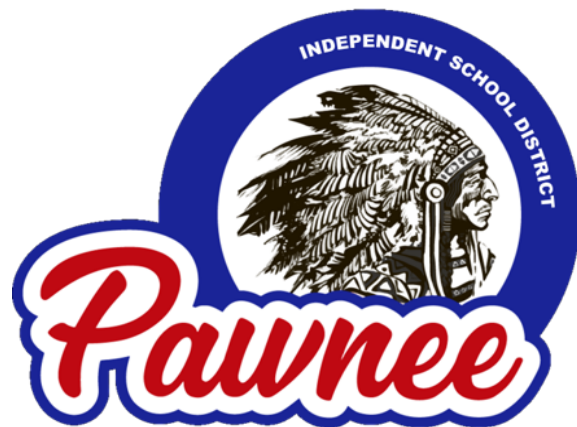**Pawnee Independent School District**
PO Box 569
Pawnee, Texas 78145
Phone 361-456-7256 fax 361-456-7388
www.pawneeisd.net

Michelle Hartmann, Superintendent
Kendra Wuest, Principal

PRESCRIPTION MEDICATION PERMIT/PARENT PERMISSION

Name of Student_____ DOB_____ Grade_____

Medication(Generic if used)_____

Dosage_____ Time to be given at school_____

Diagnosis/Reason medication be given_____

Allergies:_____Possible Adverse Reaction_____

Inhalant Medications
The student is both capable and responsible for self-administering this medication:
No_____ Yes_____ Supervised_____ Un-Supervised_____
This student may carry this inhalant medication at school/school related events:
Yes_____ No_____

Physician Name_____ Physician Signature_____
Date of Request_____ Physician Phone Number_____

I understand that medication will be given and/or monitored by a campus nurseor designate of the principal. There is no liability on the part of Pawnee ISD employees for the administration of medications requested by the parent/guardian and physician for adverse reactions or side effects to the medication. I agree to be responsible for maintaining an adequate supply of medications at the school to meet the students needs. This medication will be brought to school only by a parent/guardian. My child will not be in possession of any medication at any time unless they have written permission from a physician stating they have a condition that requires immediate treatment. Medication must be in the original container and must be properly labeled with an affixed prescription label which includes student name, name of medication, number of tablets, capsules, volume of liquid, and times to be administered as defined by the Pawnee ISD policy. This medication will be discarded if it is not picked up by a parent/guardian in accordance with the Nurse Practice Act, Texas Administrative Code, Section 217.11, The school nurse has the responsibility and authority to refuse to administer medications that in the nurse's judgement are not in the best interest of the student.

I hereby authorize the exchange of medical information regarding my child's medication treatment plan between the physician and Pawnee ISD Health Services Department.
The very first dose of a medication for current condition/illness will NOT be given at school.

I/We, the undersigned, the parent/guardian request that the above medication/treatment be administered to my child as prescribed by the physician.

Parent Signature_____ Date_____

Phone Number_____