DEER PARK INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION

Student Name_____ DOB_____
Last First MI

1. Medications given more than 10 days require a physician's signature.
2. Parent/guardian signature is required for the administration of any medication.
3. Prescription and non-prescription medication must be in the original container.
4. Changes in the administration of prescription drugs including dose and time must be in writing from the physician. Discontinuance must be in writing from the parent/guardian and/or physician.
5. Medication label must contain the patient name, name of the medication, directions for use and date.
6. Changes in the administration of non-prescription medications must be in writing from the parent/guardian and/or physician.
7. Physician orders for medications are valid only for the current school year.
8. Permission to administer "missed doses at home" must be in writing. Fax and email are permissible. Original must follow within 48 hours.
9. PRN meds may not be administered more than four times in one month. **No narcotic pain medications will be given at school.**
10. Medication should be delivered to and picked up from the clinic by a parent or authorized adult.

Parent/Guardian: Please give permission for school administration of medication

Medication	**Dosage**	**Time**	**Duration**

Start Date _____ Allergies _____

Special Instructions _____

Condition for which drug is to be given _____

Medications currently taken at home _____

Note: Non-prescription medications taken more than 4 times a month will require a physician's order (signature is required) indicating maximum dosage allowed per month.
Parent/guardian must sign the bottom of the medication form.

PHYSICIANS: PLEASE WRITE ORDER FOR SCHOOL ADMINISTRATION

Prescription medication given more than 10 days, non-prescription medication given more than 4 times in a month, or non-prescription medication when dosage is more than the recommended dosage on the container require a physician's order.

Medication	**Dosage**	**Time**	**Duration**

Start Date _____ Allergies _____

Special Instructions _____

Condition for which the drug is to be given _____

Medications currently taken at home _____

Physician name (print) _____ Physician signature _____

Phone number _____ Fax number _____ _____ Date _____

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions, and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed regarding this medication, and that medication information may be shared with school personnel who need to know.
I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and pick up remaining medication and equipment or it will be properly destroyed.

Parent/Guardian Signature _____ Date _____

Daytime Phone _____ _____ Alternate Phone _____