Administration of Medications at School Authorization Form

Student's Name: ____ DOB: ___________________

Campus: _________________ Grade: __________ Allergies: ____________________________________

PART 1- TO BE COMPLETED BY THE PARENT/GUARDIAN

Prescription: ☐ New ☐ Renewal

If new, the first full day's dosage was given at home on: ____

List all medications student is taking, including over-the-counter medications:

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I hereby request and authorize The University of Texas at Tyler University Academy staff to administer prescribed medication as directed by the physician. I agree to release, indemnify, and hold harmless The University of Texas at Tyler University Academy and any of their staff members from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided The University of Texas at Tyler University Academy staff are following the physician's order as written in Part II below. I have read the procedures outlined on the back of this form and assume the responsibilities as required.

____________________________	_____________________	____________________
Parent/Guardian Signature	***Phone Number***	***Date***

PART II-TO BE COMPLETED BY THE PHYSICIAN (signature required) Student Name:____________________

The University of Texas at Tyler University Academy discourages the administration of medication to students in school during the school day. Any necessary medication that possibly can be administered before and after school should be so prescribed. Only non-parenteral medications are administered except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication to students during the school day and while participating in outdoor education programs and overnight field trips, according to the procedures outlined in the following sections.

Please List Each Medication Separately

Name of Medication: ______________________________ Dosage: _________________________Time: __________

Trade name and/or generic Ranges not accepted (i.e. 1-2 tabs)

Special instructions: ____

Condition for which the medication is prescribed: ____

Side-effects and precautions: ____

Route of Administration: ____

Effective Dates: ___________________ to ___________________

Name of Medication: ______________________________ Dosage: _________________________Time: _________

Trade name and/or generic Ranges not accepted (i.e. 1-2 tabs)

Special instructions: ____

Condition for which the medication is prescribed: ____

Side-effects and precautions: ____

Route of Administration: ____

Effective Dates: ___________________ to ___________________

Name of Medication: ______________________________ Dosage: _________________________ Time: ________

Trade name and/or generic Ranges not accepted (i.e. 1-2 tabs)

Special instructions: ____

Condition for which the medication is prescribed: ____

Side-effects and precautions: ____

Route of Administration: ____

Effective Dates: ___________________ to ___________________

*****PLEASE ATTACH A SEPARATE SHEET IF ADDITIONAL MEDICATIONS ARE REQUIRED*****

If PRN, please specify: **Student Name**:______________________

When indicated (signs/symptoms): ____

Frequency of administration: ____

Ranges not accepted (i.e. every 2 to 4 hours)

Physician's Signature:______________________**Physician's Printed Name**: ______________________

Physician's Telephone: ______________________ **Fax:** ____________________ **Date:** _______________

SELF-CARRY/SELF-ADMINISTRAION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medications such as inhalers and EpiPens® **must** be authorized by the prescriber and be approved by the school nurse according to the State Medication policy.

Prescriber's authorization for self-carry/self-administration of emergency medication:

_______________________________________ _____________________________

Physician's Signature ***Date***

School (RN)/Principal's approval for self-carry/self-administration of emergency medication:

_______________________________________ _____________________________

School Nurse/Principal Signature ***Date***

PART III-TO BE COMPLETED BY THE PRINCIPAL OR SCHOOL NURSE

Check as appropriate:

- ○ Parts I and II above are completed, including signatures. (It is acceptable if all items of information in Part II are written on the physician's stationary/prescription blank)
- ○ Prescription medication is properly labeled by a pharmacist.
- ○ Medication label and physician order are consistent.
- ○ Over-the-counter medication is in an original container with the manufacturer's dosage label and safety seal intact.

Date any unused medication is to be collected by the parent or guardian (within one week after expiration of the physician's order): ________________________ **Date IHP Completed**: ___________________________

__________________________________ _____________________________

School Nurse/Principal Signature **Date**