Tioga ISD Health Services

Authorization and Order for Medication Administration

Student Name ____________________________ DOB _______________

Teacher _________________________________

A. Only medications that cannot be given outside the school hours will be administered. All medications must be in the original, properly labeled container. The school nurse and/or health assistants will not give the first dose of a new medication.
B. All medications to be administered at school must be FDA approved. Supplements, home remedies, herbs, vitamins, homeopathics, clinical trial medications and other non-regulated substances will not be given.

Medication	Route	Dosage	Frequency	Indication for Use
1.				
2.				
3.				

Physician Name ____ Date _____________________________________

Physician Signature _____________________________________ Fax _____________________________________

Phone _______________________________

This form is valid for one school year. Physician/Dentist must be licensed to practice in Texas. Temporary (2 months) orders for out of state US Physicians are acceptable to initiate treatment for transferring students. All prescription medication requires a physician signature. A physician's signature is required for daily or as needed therapy lasting over 5 days or changes in the original prescription order. Narcotic medication will **not** be given at school.

I request and authorize Tioga ISD to administer the above mentioned medication as prescribed. I understand that the school administrator may designate any qualified person or persons to administer this medication including while staff is off campus on school related activities. I also understand that although a reasonable attempt will be made to remind the student, it is expected that the student will be responsible in most situations for remembering to visit the health room/clinic for his/her medicine.

I authorize the school's registered nurse, or health assistant , and the prescribing physician to discuss and/or clarify this medication order or in the interest of this student's health, to discuss his/her response to the prescribed medication as required by the Nurse Practice Act and Medical Practice Acts of Texas. If the consent for the nurse, or health assistant, and the doctor to consult regarding this medication order is not granted or is revoked, it may not be possible for school personnel to administer the prescribed medications.

Parent please initial:

_______ **Students are not permitted to transport medications to and from school.**

_______ **Unused medications not picked up at the end of the school year or within 5 days of being discontinued will be disposed of.**

Parent/Guardian Signature ____________________________________
Telephone ___________________________________ Date ______________________
Medication Expiration Date__________________________ (expired medication will not be given)

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Student name: ________________________ Grade:________

Name of Medication:______________________ Beginning Date:_______ End Date:________

Dosage:_______________