Farmersville ISD School Health Services

Over-the-Counter Medication Administration Form

PARENT'S REQUEST FORM FOR THE ADMINISTRATION OF OVER-THE-COUNTER MEDICATION TO A STUDENT

Parents or guardians must adhere to the following guidelines:

1. ALL medication will be kept in the nurse's office.

2. Medications may only be given at school **if they cannot be scheduled before or after school hours.**

3. All prescription & nonprescription medications must be in the **original bottle**, bearing a label with the student's name. All prescription medication MUST be in the original container with a pharmacy prescription label. No more than one month's supply of medication in a prescription labeled bottle shall be brought to the clinic at one time. **All prescription medication given over ten days will REQUIRE a physician's signature.**

4. Over-the-counter medications will be given according to the label on the packaging and must be age-appropriate. ***OTC meds will not be given longer than ten days without Doctor's orders.***

5. FISD **will not** administer any expired medications.

6. At the request of T.E.A., the school district **will not** provide any over-the-counter medications (i.e., Tylenol, ibuprofen, etc.)

7. When routine medication is changed, **the new labeled bottle must be provided.** The parent will alert the school of medication changes.

8. **It is the student's responsibility to come to the nurse's office at the necessary time to take their medication.**

Note: We cannot store any medications at the school during the summer & will dispose of all medicine left after the last day of school.

Name of Student:____

Date of Request:______________________

Birth Date:____

Grade:_______________________________

Campus:____

Homeroom Teacher/Class:_______________________________________

Name of Medication:____

Expiration Date:___________________________

Condition for which medication is to be given:____

____

Amount to be given:____

Time:_______________________________

Special Instructions:____

____

Discontinuation Date:____

I consent to the release of the medical information contained on this to form school officials who have legitimate educational interest in the information, according to the Family Education Right

and Privacy Act. I give my permission for the release of confidential information regarding my child's specific health problems to third parties, other than school officials, as required to facilitate medical care and/or treatment of my child. I authorize the nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

Signature of Parent or Guardian:____

Printed Name of Parent or Guardian:____

Daytime Phone Number: ________________________________