Farmersville ISD School Health Services

Prescription Medication Administration

PARENTAL REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION 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 package, 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.

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:_____

Student's Date of Birth: _____

Grade:_____

Campus:_____

Homeroom Teacher/Class:_____

Medication and Dosage:_____

Condition for which medication is to be given:_____

_____

Amount to be administered:_____

_____

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 Rights and Privacy Act. I give my permission to release 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

_____

Daytime Phone Number

Please have the physician complete if medication is to be given for longer than ten days.

_____

Printed Name of Physician

_____

Signature of Physician

_____

Physician's Phone Number

****Student has been trained and observed in the use of their inhaler. This student should be allowed to carry their inhaler with them at all times.**

_____

Physician's Signature