Authorization and Permission for Medication Administration

Student's Name ____ DOB: ______________________
Last First

Teacher/Grade ______________________________ ID#__________________ School:____________________

Received By:____ Date Received:______________________

School Medication Policy: (For entire policy, please visit MISD website: www.misd.org)

- Physician's signature is required for any prescribed medication taken >14 days
- **(Physician's signature must be obtained before giving any controlled substance).**
- Parent signature and date authorized is required prior to administration of the medication
- All medication must be in the original container and cannot be expired
- Prescription medication must contain student name, name of medicine, directions and expiration date
- Medication changes: must be in writing and prescriptions require a new pharmacy bottle
- This form must be completed annually and all medication must be picked up prior to the last day of school

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Medication Dosage Time

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Medication Dosage Time

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Medication Dosage Time

Special Instructions/Allergies: ____

Other medications student is on: ____

Condition for which drug is to be given: ____

Physician's Name: ______________________________ **Telephone Number:** ________________________

Physician's Signature: ______________________________________ **START 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 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 that **No student will carry or transport medication to and from school.**

Comments: ____

Parent/Guardian Signature: ____ **Date**: ______________________

______________________________________ ______________________________________
Email Daytime Telephone Number

STUDENT NAME: ____

Medication:			
Dose/Time:			
DATE:	Time:	Dose:	Initials:

Medication:			
Dose/Time:			
DATE:	Time:	Dose:	Initials:

Medication:			
Dose/Time:			
DATE:	Time:	Dose:	Initials:

Signature: ______________________ Initials ________

Signature: ______________________ Initials ________

Signature: ______________________ Initials ________

Signature: ______________________ Initials: ________

Signature: ______________________ Initials: ________

Signature: ______________________ Initials ________