KELLER INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT

MEDICATION AUTHORIZATION FORM

Only medications that are required to enable a student to stay in school may be administered at school. Medication will be administered at school under the following conditions:

1. **MEDICATION MUST BE IN ORIGINAL PROPERLY LABELED CONTAINER, dated for the current school year and brought to school by an adult. MEDICATION SENT IN BAGGIES OR UNLABELED CONTAINERS WILL NOT BE GIVEN.**
2. **Prescription medications will only be administered with a specific written request signed by at least one parent/guardian. Physicians must be licensed to practice medicine in the State of Texas. The prescription label will serve as the physician's signature.**
3. **A trained unlicensed employee may administer the medication.**
4. **All medications must be kept in the clinic, except for students whose physician and parent furnishes the school with a written permit to carry an inhaler or epi-pen on their person. A second inhaler or epi-pen must be kept in the clinic.**
5. **Aspirin or products containing aspirin should not be given to students under the age of 18 without a physician's order.**
6. **FDA APPROVED OVER THE COUNTER MEDICINE REQUIRES PARENT/GUARDIAN WRITTEN PERMISSION AND MAY NOT BE GIVEN FOR MORE THAN 7 DAYS IN A SCHOOL YEAR WITHOUT A DOCTOR'S WRITTEN ORDER.**

Please speak to the school nurse if your child requires long-term medication, any health procedure, or monitoring.

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

STUDENT_____ **DATE**_____

TEACHER_____ **GRADE** _____ **AGE**_____

MEDICATION_____ **DOSAGE**_____ **TIME**_____

Route of Medication Administration: _____

Potential Side Effects: _____

PARENT/GUARDIAN CONSENT:

I give my permission for the above medication to be given to my child at school or on school sponsored field trips, as applicable. I understand that the medication may be given by an authorized KISD employee. I consent to and authorize the healthcare provider to disclose health information to the school, and for the school to disclose the above information to those within the school district that have a need to know for legitimate educational purposes.

_____

Parent/Guardian Signature **Date**

_____

Home Phone # **Business/ Cell phone #**

_____

Physician's Signature **Physician's Phone #**

Updated 9-2017