KELLER INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

MEDICATION AUTHORIZATION FORM

Only medications that are required to enable a student to stay in school may be given at school. Three times a day medication should be given before school, after school, and at bedtime. If necessary, medication can be given at school under the following conditions:

1. **MEDICATION MUST BE IN ORIGINAL PROPERLY LABELED CONTAINERS** dated for the current school year and brought to school by an adult. Medications must be age appropriate**.**
   MEDICATION SENT IN BAGGIES OR UNLABELED CONTAINERS WILL NOT BE GIVEN.
2. Prescription medications will be given only with a specific written request signed by at least one parent/ guardian. Physicians must be licensed to practice medicine in the USA. The prescription label will serve as the physician's signature. This request form may be obtained at the school or on the Keller ISD website (www.kellerisd.net).
3. A medically untrained person may administer the medication.
4. All medications must be kept in the clinic, except for students whose doctor and parent furnishes the school with a written permit to carry an inhaler on their person. A second inhaler must be kept in the clinic.
5. Please speak to the school nurse if your child requires long-term medication, any health procedure, or monitoring.
6. Aspirin or products containing aspirin should not be given to students under the age of 18 without a doctor's order.
7. **FDA APPROVED OVER THE COUNTER MEDICINE REQUIRES PARENT/GUARDIAN WRITTEN PERMISSION AND MAY NOT BE GIVEN LONGER THAN 7 DAYS WITHOUT A DOCTOR'S WRITTEN ORDER.**

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

STUDENT____ DATE______________________________

TEACHER____ GRADE____________ AGE __________

MEDICATION____ DOSAGE___________TIME__________

MEDICATION____ DOSAGE___________TIME__________

PARENT/GUARDIAN CONSENT:
I give my permission for the above prescription medication(s) to be given to my child at school or on school sponsored field trips. I understand that the medication may be given by an authorized KISD employee.
I consent to and authorize the health care 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 Relationship to student

____
Home Phone # Business/ Cell phone #

____
Physician's Signature Physician's Phone #

KELLER INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

GUIDELINES FOR SELF-ADMINISTRATION OF ASTHMA/ANAPHYLAXIS MEDICATIONS:

A student with asthma or anaphylaxis may possess and self-administer prescription asthma or anaphylaxis medicine while on school property or at a school-related event or activity if:
1) the medicine has been prescribed for that student as indicated by the prescription label on the medicine;
2) the student has demonstrated to his/her physician or other licensed health care provider and the school nurse, if available, the skill level necessary to self-administer the prescription medication, including the use of any device required to administer the medication;
3) the self-administration is done in compliance with the prescription or written instructions from the student's physician or other licensed health care provider; and
4) the parent of the student provides written authorization to the school, as follows:
____

I have instructed ____ in the proper way to use his/her medication.

Diagnosis/Purpose of Medication ____

Name of Medication ____

Dosage of Medication ____

Time/Frequency ____

Duration of Medication ____

It is my professional opinion he/she is capable of using the medication properly and should be allowed to carry and use the medication by him/herself.

Physician's Signature ______________________________Date______________________

Parent's Signature_________________________________Date______________________