



School: \_\_\_\_\_

Teacher: \_\_\_\_\_

Grade: \_\_\_\_\_

### Medication Administration Permission Form

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Student ID#: \_\_\_\_\_

Medication and food allergies: \_\_\_\_\_

Other medications taken at home: \_\_\_\_\_

7 R G D \ \ V ' D W H \_\_\_\_\_ This medication form is valid for the current school year: 20 \_\_\_\_ - 20\_\_

Students in grades PreK-12 **ARE NOT ALLOWED** to carry any medication, prescribed or over the counter, or to self-administer the medication unless ordered by a U.S licensed medical practitioner for diabetes, asthma and D Q D S K \ \ O D [ L V By law the only medications with a medical order/permission that may be carried by a student is an asthma inhaler, EpiPen, and/or insulin/diabetes.

Austin ISD Health Services and Nursing require the following:

- ⊕ Only those medications that are medically necessary during school hours for a V W X G H Q W \ \ V attendaniteorin an IEP should be sent to school. The first dose of a medication may not be given at school.
- ⊕ A U.S. medical S U D F W L W I T E R O r d e r / p e r m i t t e n t or guardian consent dated for the CURRENT school year and signed by the parent, legal guardian or other person(s) having legal authority of the student AND the medical practitioners who D U H licensed to practice medicine in the United States/State of Texas.
- ⊕ Medication P X V W n t h e o r i g i n a l , p r o p e r l y l a b e l e d c o n t a i n e r f r o m a r e g i s t e r e d p h a r m a c i s t ( n a m e o f t h e s t u d e n t , n a m e o f t h e m e d i c i n e w i t h s t r e n g t h , d o s a g e a n d d i r e c t i o n s ; r o u t e t o b e g i v e n , n a m e o f p r e s c r i b i n g P H G L F D O S U R Y L G H U licensed in Texas, and current date .
- ⊕ Non-prescription and over-the-counter medications require the above (AISD Student Handbook, FFAC local).

MEDICATION ADMINISTRATION INST 5UCTIONS						
Medication Name and Strength	Dosage	Time(s) to Give Medication at School	How Medication is Taken (by mouth, eye, ear nose, tube, inhaler, with a topical cream or injection)	Condition for which Medication is Given	Stop Date	Medication Expiration Date written on Bottle

Special medication instructions: \_\_\_\_\_

All unclaimed medication Q R W S L F N w i l l b e d i s p o s e d o f o n t h e l a s t d a y o f s c h o o l a s r e q u i r e d b y l a w .

- x I request authorized Austin ISD to administer the medication(s) listed on this form to my child during school hours to include field trips according to medication label and/or P H G L F D O S U R Y L G H U any changes in medication and/or G R V D U H T X D O H Z P H G L F D O S U R Y L G M U J J R D O \ X W H D Q G
- x I release school staff from liability in the event of ill effects that may occur with administration of a medication.
- x I agree to abide by federal and state law and Austin ISD guidelines for medications in the school setting.
- x I understand that the school nurse may designate trained Austin ISD staff to administer medication(s).



\_\_\_\_\_  
Parent/guardian name (print) Date

' YES ' NO - I have instructed this student and give my permission for the self- carry of their emergency asthma and/or anaphylactic allergy medication. Check applicable: ' Inhaler ' EpiPen ' Diabetes medication/insulin



0 H G L F D O S i g n a t u r e R e v i e w e d b y : 0 H G L F D O S a m e ( p r i n t o u t l i n e ) t h e ( t h e ) D a t e ( ( p r i n t ) ) T J D / S p a n < 2.85 >>  
RN Printed Name

Date

\_\_\_\_\_ may / \_\_\_\_\_ may NOT administer this medication

Escuela: \_\_\_\_\_

Maestro: \_\_\_\_\_

Grado: \_\_\_\_\_

## Formulario de autorización para la administración de medicamentos

Nombre del estudiante: \_\_\_\_\_ Fecha de nacimiento: \_\_\_\_\_ # de identificación del estudiante: \_\_\_\_\_

Medicamento y n6p16 Td [(MBT /TT6o Q e)-2.00g96 6754en04 (i)-5 (eC/Doy4s4dre (ha d)-60.86 Td [(M gs 0 0 m 42.96 0 l S2u)4 004 6 0 l

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