Health Services

Teacher_____

Medication Request and Authorization

DOB_____

Student ID #_____

Student name: _____ **Drug Allergy: No □ Yes □**_____

Medication:_____**Expiration Date:** _____

Dosage:_____ **Route: (circle) Oral Inhaled Apply to skin Other**_____

Time to be given:_____**Days to be given**_____

Reason for medication: _____

Special Instructions: _____

□ Student may take morning dose of medication, if forgotten at home, with telephone permission from parent.

Is this the initial dose of a new medication? No □ Yes □

- For student safety, all medications should be brought to the clinic by the parent. Controlled substances must be brought to the clinic by the parent.
- All medications must be in its original container (box or bottle) with the instructions clearly printed on it. Medication in baggies will not be accepted and medication in blister packs that does not have administration and side effect information will not be accepted. Allen ISD does not supply medication. No expired medications.
- A separate permission form is required for each medication. Medication authorization is valid for one school year.
- Aspirin or products containing aspirin will not be given without a physician order.
- Sample medicines are accepted only with written order from a physician.
- Inhalers must have prescription label on inhaler or box.
- All medicine not picked up by the last day of school will be discarded.
- Authorized district employees may administer medication in the absence of the nurse.
- A physician's written order may be required if an over-the-counter medication is to be given more than 3 times per school week
- All medication including homeopathic medication, dietary supplements and herbal supplements will only be given in accordance with Allen ISD Board Policies FFAC (LEGAL) and FFAC (LOCAL).

By my signature below, I affirm that it is impossible to schedule the above-mentioned medication at a time other than school hours. I request that this medication be given by a school employee. I acknowledge that I will not hold the Allen ISD, Board of Trustees, and/or District employees for damages or injuries resulting from administration of this medication (prescription/nonprescription/ homeopathic/over-the-counter), dietary supplement and/or herbal supplement.
I consent for the District's designee, including District medical professionals, to share/obtain my student's health related information with the medical health professional or health care provider identified below, in order to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's Individual Health Plan (IHP), 504 plan, Individual Education Plan (IEP), or other AISD form requesting school health care services. School nurse services requested and authorized herein require my signature below.

Parent/Guardian Signature:_____**Date:** _____

Phone number:_____**Email address:** _____

Student's Health Care Provider:_____**Phone:** _____

Physician Signature:_____**Date:** _____