Health Services

Teacher: _____

DOB: _____

Student ID #: _____

Medication Request and Authorization

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. No □ Yes □

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

- For student safety, all medication should be brought to the clinic by the parent. Controlled substances must be brought to the clinic by the parent.
- All medication must be brought to the clinic in the smallest possible unopened original container (box or bottle) with the instructions clearly printed on the label. Medication in baggies will not be accepted and medication in blister packs that do not have administration and side effect information on it will not be accepted. No expired medications.
- A separate permission form is required for each medication. Medication authorization is valid for one school year.
- Inhalers must have a valid prescription label with the student's name on the 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.
- Parent provided nonprescription medication from a district-approved list may be given up to 10 days per year (5 consecutive days for students under 12 years) without a physician's signature/order. A physician's signature/order is required for off label medication, medication samples, and nonprescription medications that are not on the district-approved list.
- Changes in medication dosage require a new physician signature/order and a new parent authorization form.
- Homeopathic medication, dietary supplements, and herbal supplements will only be given in accordance with Allen ISD Board Policies FFAC (LEGAL) and FFAC (LOCAL) as part of the student's IEP or 504 plan.

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 Print Name: _____ Phone: _____

_____ (physician's initials) I have determined the off-label medication is necessary at school and further state that this medication has been clinically determined to be safe and effective based on this student's health needs.

I request and authorize the above medication, dosage, and frequency.

Physician Signature: _____ Date: _____