MANSFIELD ISD HEALTH services

Medication Authorization Form

Name of School: _____ **School Year: _____**

The school nurse or other trained non-licensed personnel may administer medication when such treatment is necessary for school attendance. All medications, given three times per day or less, should be given outside school hours. Medication will be administered at school under the following conditions;

All Medications: Prescription & Non-Prescription

- Will be provided by the parent/guardian.
- Will be administered by the school nurse or other trained non-licensed employee designated by the superintendent designee
- Must be in the original container, be properly labeled, dated for the current school year and not expired.
- Will be stored in the clinic unless written authorization is provided (below) to self- carry an inhaler or epi-pen
- Must be picked up from the clinic by the last day of school. All remaining medication will be destroyed.

Prescription Medications:

- A written request by a physician or other healthcare professional with authority to write prescriptions in the state of Texas shall be required when the prescription medications must be administered longer than 10 days.
- The first dose should be given at home to monitor for any side effects.
- Prescription medication should be transported by an adult to and from school.
- Changes in medication or dosage require a new physician written order/signature and parent/guardian signature
- Only a 30-day supply will be accepted at a time.

Non-Prescription Medications:

Administration of non-prescription medication provided by a parent will be allowed on an "as needed basis" OR for up to five consecutive school days with parent/guardian written request and signature.

STUDENT INFORMATION

Name_____ DOB_____ Grade_____ Teacher/Advisor_____

MEDICATION/PHYSICIAN INFORMATION

Medication Name_____ Start Date_____ End Date_____

Medication Dose_____ Route_____ Time or Frequency given at school_____

Diagnosis/Reason for Medication _____

Physician Name (Please print)_____ Physician Phone Number_____

PHYSICIAN SIGNATURE_____ Date_____

PHYSICIAN AUTHORIZATION FOR EPI-PEN AND/OR INHALER TO BE CARRIED ON PERSON AND SELF-ADMINSTERED

In my opinion, it is necessary for the above named student to carry and self -administer their Epi-pen and/or rescue inhaler. Student has demonstrated ability to correctly administer medication and understands dosage and frequency. A backup Epi-pen and/or inhaler should be supplied to clinic for emergencies. ☐ **Epi-Pen** ☐ **Inhaler**

Physician Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

PARENT AUTHORIZATION; My signature indicates that I request that MISD staff administer the medication specified to my child and I am giving permission for MISD staff to contact the physician for additional information, if needed.

PARENT/GUARDIAN SIGNATURE_____ Date_____

Staff Signature _____ Date received in clinic_____