

Academy ISD Health Services

Parental/Physician Authorization for Administration of Medication

Section 1: Parent/Guardian/Physician MUST fill out every box of this section and SIGN or this medication CANNOT AND WILL NOT BE ADMINISTERED AT SCHOOL. Medication MUST be in its ORIGINAL bottle with proper label and will only be given based on those instructions. Include doctor's note if prescription label is different than how medication will be administered. Over-the-counter medications will not be given more than 5 consecutive days or against label's recommendations (age/weight requirements, or for longer than recommended) without a doctor's signature/note. Expired medications will not be given. See AISD website under Health Services for more guidelines.

Student	DOB	Grade/Homeroom #
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Medication	Dose/Route/Time(s)
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Specific instructions/Precautions/side effects on your child:

Pharmacy	Expiration Date	Condition for which medication is required:
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- No Yes Is this the initial dose of a new medication that has not been previously given to your child?
- No Yes If lunch med: My child is to receive medication prior to release on early dismissal days.
- No Yes Will your child need this medication during field trips? If yes, please ask your pharmacy to provide the school with an EXTRA properly labeled empty container.

My signature below indicates that I request and grant permission to ACADEMY ISD to administer medication to my child. I am giving permission to AISD staff to contact my physician for additional information if necessary. If the school nurse deems it necessary, I grant permission to notify my child's teacher(s) of possible reactions that might occur while taking this medication.

- I understand that unlicensed school personnel assigned by the principal may give the medication.
- I understand that a new authorization from the parent and physician is required for any change in dosage or time of the medication.
- I understand that my child cannot carry this medication unless permitted by law, and that a parent/guardian should bring and pick up any medication given at school.
- I understand that all medication will be disposed of on the last day of school unless picked up by parent.
- I understand that I am to read and understand the school guidelines posted on the AISD website for medication administration at school and provide additional forms and documentation as needed.

Parent (print)	Parent Signature	Date
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Parent Email	Phone	Other Phone
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Section 2: for Physician (if needed). Additional Physician Instructions:

Physician (print)	Physician signature	Date
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Phone	Hospital/Clinic/Department/Specialty
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Section 3: AISD STAFF ONLY

MEDICATION COUNT

Date	Accepting(+)	Picking up(-)	Total #	Counter signature	Witness signature

AISD MEDICATION LOG

Student:	Date of Birth:	School Year:
Medication:	Dosage:	Time:

Special Instructions:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AUGUST																															
SEPTEMBER																															
OCTOBER																															
NOVEMBER																															
DECEMBER																															
JANUARY																															
FEBRUARY																															
MARCH																															
APRIL																															
MAY																															

*****Sign below if you administer this medication*****

Signature:	Initials:
Signature:	Initials:
Signature:	Initials:
Signature:	Initials:
Date Medication Form/Medication Received in Office:	
Received by:	

Document	H=Holiday	A=Absent	O=Out of Medication
Once/day			
Time			
Initials			
Twice/day			
Time			
Initials			
Time			
Initials			
N=Note P=Parent Permission to Hold			
Notes:			