AUSTIN Independent School District | Health Services and Nursing

School: _____
Teacher: _____
Grade: ____

Medication Administration Permission Form

Student Name: _____ Date of Birth: _____ Student ID#: _____

Medication and food allergies: _____

Other medications taken at home: _____

Today's Date: _____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 anaphylaxis. **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 student's attendance or written in an IEP should be sent to school. The first dose of a medication may not be given at school.**
- A U.S. medical practitioner's written order/parent 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 is licensed to practice medicine in the United States/State of Texas.
- Medication in the original, properly labeled container from a registered pharmacist (name of the student, name of the medicine with strength, dosage and directions; route to be given, name of prescribing physician who is licensed in Texas, and current date.
- Non-prescription and over-the-counter medications require the above (AISD Student Handbook, FFAC local).

MEDICATION ADMINISTRATION INSTUCTIONS					
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**	**Medication Expiration Date written by**

Special medication instructions: _____

All unclaimed medication will be disposed of on the last day of school as required by law.

- 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 physician instructions. **Any changes in medication and/ or dosage require a new physician's order and signature.**
- I release school staff from liability in the event of ill effects that may occur with administration of a medication.
- I agree to abide by federal and state law and Austin ISD guidelines for medications in the school setting.
- I understand that the school nurse may designate trained Austin ISD staff to administer medication(s).

SIGN HERE _____ _____ _____
Parent/guardian signature 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

SIGN HERE _____ _____ _____
Physician signature Physician name (print or stamp) Date

Reviewed by: _____ _____ _____
RN Printed Name RN Signature Date

Campus Health Room Assistant _____ may / _____ may NOT administer this medication