



School: _____

Teacher: _____

Grade: _____

Medication Administration Permission Form

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

Medication and food allergies: _____

Other medications taken at home: _____

7 R G D \ \ V ' D W H _____ 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 D Q D S K \ \ O D [L V 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 V W X G H Q W \ \ V attendaniteorin an IEP should be sent to school. The first dose of a medication may not be given at school.
- ⊕ A U.S. medical S U D F W L W I T E R O r d e r / p e r m i t t e d by 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 D U H licensed to practice medicine in the United States/State of Texas.
- ⊕ Medication P X V W n t h e o r i g i n a l , p r o p e r l y l a b e l e d c o n t a i n e r f r o m a r e g i s t e r e d p h a r m a c i s t (n a m e o f t h e s t u d e n t , n a m e o f t h e m e d i c i n e w i t h s t r e n g t h , d o s a g e a n d d i r e c t i o n s ; r o u t e t o b e g i v e n , n a m e o f p r e s c r i b i n g P H G L F D O S U R Y L G H U licensed in Texas, and current date .
- ⊕ Non-prescription and over-the-counter medications require the above (AISD Student Handbook, FFAC local).

| MEDICATION ADMINISTRATION INST 5UCTIONS | | | | | | |
|---|--------|--------------------------------------|---|---|-----------|--|
| 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 | Stop Date | Medication Expiration Date written on Bottle |
| | | | | | | |
| | | | | | | |

Special medication instructions: _____

All unclaimed medication Q R W S L F N w i l l b e d i s p o s e d o f o n t h e l a s t d a y o f s c h o o l a s r e q u i r e d b y l a w .

- x 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 P H G L F D O S U R Y L G H U any changes in medication and/or G R V D U H T X D O H Z P H G L F D O S U R Y L G M U J J R D O \ X W H D Q G
- x I release school staff from liability in the event of ill effects that may occur with administration of a medication.
- x I agree to abide by federal and state law and Austin ISD guidelines for medications in the school setting.
- x I understand that the school nurse may designate trained Austin ISD staff to administer medication(s).



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



0 H G L F D O S i g n a t u r e R e v i e w e d b y : 0 H G L F D O S a m e (p r i n t o u t l i n e) t h e (t h e) D a t e ((p r i n t)) T J D / S p a n < 2.85 >>
RN Printed Name

Date

_____ may / _____ may NOT administer this medication

Escuela: _____

Maestro: _____

Grado: _____

Formulario de autorización para la administración de medicamentos

Nombre del estudiante: _____ Fecha de nacimiento: _____ # de identificación del estudiante: _____

Medicamento y n6p16 Td [(MBT /TT6o Q e)-2.00g96 6754en04 (i)-5 (eC/Doy4s4dre (ha d)-60.86 Td [(M gs 0 0 m 42.96 0 l S2u)4 004 6 0 l

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