BISHOP CISD

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Name of Student: _____ DOB: _____

School: _____ Grade: _____ Teacher: _____

Drug allergies: _____

Name of Physician: _____ Number: _____

Name of Medication: _____

Dose of Medication: _____

Time to be given: _____

Reason for taking medication: _____

Expiration Date of medication (responsibility of parent): _____

Will this be the first dose of a new medication for your child? _____ Yes _____ No

Special instructions/ precautions/ side effects of this medication for your child? _____

_____

Medication must be supplied in the original container/ prescription bottle.

I affirm that it is impossible to schedule the above medication at a time other than school hours.

I request that the above medication be given, by a school employee, during school hours as prescribed. I also request the medication be given on field trips or other school sponsored activities, as prescribed.

I release school personnel from liability in the event of adverse reactions from taking this medication. I will notify the school of any change in the medication (ex: dosage change, medication is discontinued, etc.).

I give permission for the school nurse to communicate with the student's teachers about the student's medical condition.

I give permission for the school nurse to consult with the student's physician regarding any questions that arise with regard to the listed medication.

Parent/Guardian Signature: _____ Date: _____

A physician's signature is required to administer over-the-counter medication for more than 10 consecutive days.

Physician's Signature: _____ Date: _____