Authorization for Medication Administration

Date: ________________

Student Name: ______________________________________ ID: _____________ Birth Date: ____________

Home/Cell ____________________ Grade: ____________ Teacher: ________________________ Gender M/F

Phone: ____ Emergency Phone: _________________________

Pharmacy Name/Prescription #____________________________ Physician Name: ______________________

Name of Medication: ____

Dosage (including route of administration) ____

Scheduled Time to be given: _______________ or PRN: (as needed) Will be given per label directions.

Diagnosis for which medication is prescribed: ____

Do not administer after the following date: ______________________ or end of current calendar school year

I authorize the physician named below to release information regarding medication my child will take during school hours to Coupland ISD.
I request that the designated personnel of the above school district administer medication to my child, named above, according to written physician's instructions and authorize the school to exchange information with the physician or their authorized representative regarding medication and health related issues. I understand it is my parental/guardian responsibility to furnish an adequate supply of this medication in the original and properly labeled container. I understand that school district personnel will protect my child by not administering the medication if this form is not complete, the physician's authorization is not complete, or the prescribed medication is not provided. I understand it is my parent/guardian responsibility to pick up all prescription and nonI prescription medications.

***Medications cannot be sent home with the student. All remaining medications will be disposed of on the last day of school.**

Parent/Guardian Printed Name: __________________________ Parent/Guardian Signature: ___________________________

**** If medication is to be administered more than 10 days, a physician must complete and sign below. *****

Diagnosis for which medication is prescribed: ____

If asthma inhaler administered and no response to treatment, may repeat: interval _______ dose: _________
(Please provide Asthma Action Plan)

Side effects: ____

Physician Signature: ________________________________ Date: _________________________

Physician Name: ____

Office Address: ____

Physician Phone: __________________________________ Physician Fax: _______________________________

Received by: ____ Date: ________________________