

**CROSBY ISD**

*Authorization and Permission for Administration of Medication*

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Last First Middle

Teacher/Grade: \_\_\_\_\_ Date: \_\_\_\_\_ Rec'd by: \_\_\_\_\_

School Name: \_\_\_\_\_ ID: \_\_\_\_\_

**Guidelines:**

- 1) Parent signed & dated authorization to administer medication.
- 2) The medicine is in the original UNOPENED container as dispensed or the mfr's labeled container.
- 3) The medication label contains the student name, name of medication, directions for use and dates.
- 4) Over the counter medications will be given for FIVE (5) days and then must be picked up by parent/guardian. Any meds left after 5 days **WILL BE DISCARDED**. Any medical problem not resolved in 5 days needs to be evaluated by a physician.
- 5) Any prescription medication being taken >10 days requires a physician's signature.
- 6) All medications must be delivered to the school nurse by a responsible adult and must be picked up from the school by a responsible adult.
- 7) Annual renewal of authorization and immediate notification, in writing, of changes.

***TO BE COMPLETED BY PARENT/GUARDIAN:***

Medication	Dosage	Time
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Special Instructions: _____		
Allergies: _____		
Condition for which this medication is being taken: _____		
_____		
Other meds being taken: _____		
Physician Name (print): _____		
Physician Signature: _____		
Phone: _____		
Start Date: _____		End Date: _____

Pill Count		
Date	# Rec'd	Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I request the above named student be given the medication at school by designee, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel on a need to know basis.

I understand the law provides that the District, the board and its employees shall be immune from liability for damages or injuries resulting from the administration of medication to a student. I agree to provide safe delivery of medication and equipment to and from school and pick up remaining medication and equipment or it will be properly disposed of.

Comments: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_