2018-19

CROWLEY INDEPENDENT SCHOOL DISTRICT
Medication Administration Authorization Form/Elementary

Student's Name:________________DOB:_____________Allergies:____________
Date of Request__________School:___________Teacher/Grade______________

Medication Administration Policy

During the school day, the school nurse or other trained non-healthcare personnel may administer medication when such treatment is necessary for school attendance and cannot otherwise be accomplished. All medication, given three times per day or less, should be given outside school hours. For example: three times a day medication can be given before school, after school and at bedtime. If necessary for medication to be given at school the following conditions must be met:

Prescribed medications:

- The first dose must be given at home in case of unexpected allergic reaction.
- Medication must be brought in by parent in original container, properly labeled by the pharmacy. Parents must supply any special equipment necessary to administer medication.
- Medication must be FDA approved.
- Medication will not be given without specific written request signed by parent/guardian.
- Medication must be kept in the clinic. All rules regarding medication given at school still apply.

Over-the-counter medications: Same rules apply as with prescribed medications except that they can be given with parent authorization only, physician signatures are not required. The medication can only be given as directed by the manufacturer and must be FDA approved. CISD will not administer herbal supplements.

End of the school year: All medication must be picked up from clinic by the last day of school. Any medication left at the school will be disposed of by the nurse.

Medication	Dosage	Time of Administration	Route	Start/End
1.				
2.				
3.				

Condition for which medication is given, side effects for child, special instructions, pertinent information:

School Nurse:___________________________Clinic Phone#:_________________Fax#:______________
Nurse Signature after review________________________ Date received in clinic_________________

PARENT AUTHORIZATION
I request that the above medication be administered by school personnel to my child,
____
and give permission to speak with child's physician if necessary.
PHONE #________________ **Date: _____________**
Received a copy of medication rules for CISD ______
PARENT/GUARDIAN SIGNATURE:
____

School Nurse:____________________________Clinic
Phone#:_________________Fax#:______________
Nurse Signature after review_________________________ Date received in
clinic_________________