BISD Medication Authorization Form

Medication Administration Policy

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.

Prescribed medication:

- The first dose must be given at home in case of an unexpected allergic reaction.
- Medication must be brought in by parent in the original container, properly labeled by the pharmacy. Parents must supply any special equipment necessary to administer medication.
- Medication must be kept in the clinic, with the exception of inhalers and epinephrine that a physician may deem necessary for student to carry on their person. In this case, the physician must sign the appropriate box below. All rules regarding medication given at school still apply. If a student is misusing medication, the privilege will be revoked. A second inhaler/epinephrine injector should be kept in the clinic.

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

STUDENT INFORMATION

Name_____DOB_____Grade___Teacher/Advisor_____

MEDICATION/PHYSICIAN INFORMATION

Medication Name_____Start Date_____ End Date_____

Medication Dose_____Route_____Time or Frequency given at school_____

Special instructions for dosing of medication _____

Diagnosis/Reason for Medication_____

Physician Name (Print)_____Physician Phone Number_____

PHYSICIAN SIGNATURE_____Date_____

PHYSICIAN AUTHORIZATION FOR EPINEPHRINE AND/OR INHALER TO BE CARRIED ON PERSON AND SELF-ADMINISTERED

In my opinion, it is necessary for the above named student to carry and self -administer their epinephrine and/or rescue inhaler. Student has demonstrated ability to correctly administer medication and understands dosage and frequency. A backup epinephrine pen and/or inhaler must be supplied to the clinic for emergencies.

Physician Signature_____Parent/Guardian Signature_____

PARENT AUTHORIZATION

I request that the above medication be administered by school personnel to my above named child.

PARENT/GUARDIAN SIGNATURE_____ Date_____

School Nurse:_____Clinic Phone #:_____Fax#:_____
Nurse Signature: _____ Date received in clinic:_____
Student Name: _____

FOR BISD STAFF ONLY

Medication Count: (Controlled Medications Must Be Counted)

Date	Time	Med Name	# of pills in clinic	# received from(+) or returned to (-)parent	Total	Parent/Guardian Signature	Nurse Signature

End of Year Medication:

Date	Time	Med Disposition Code*	Med Destroyed Code**	Nurse Signature	2nd BISD Signature***

*Med Disposition Code: PD-Prescription Depleted; DC'D-Med Discontinued; MD-Med Destroyed; P/U-Picked Up by Parent/Guardian

**Med Destroyed Code: W-Wasted (contaminated); D-Discontinued-left in clinic; E-End of School-left in clinic; C-Student changed schools/moved-left in clinic

***2nd signature only needed if medication is wasted