01/2023

MEDICATION AUTHORIZATION
REQUIRED ANNUALLY
Independent School District #192
School Year _____

NAME: _____SCHOOL: _____ GRADE: _____
Last First Middle

DATE OF BIRTH: _____

Medication: _____Dose: _____

Medication: _____Dose: _____

Medication: _____Dose: _____

Diagnosis/Medical reason for medication(s) _____ICD 10 Code_____

Effective Date: _____
Method of Administration/Route: _____ Time to given in school: _____

Other Instructions: _____
_____

Print Medical Provider Name: _____***Clinic Name:*** _____

Physician/Medical Provider Signature _____
Telephone Number: _____ *Fax Number:* _____

PARENT/GUARDIAN AUTHORIZATION (Required ANNUALLY)

1. I request that the above medication to be given during school hours as ordered by the student's medical provider.
2. I will notify the school of any changes in the medication, i.e. dosage change, medication is discontinued.
3. I give permission for the school nurse to communicate with teachers about the dosage, action and side effects of the prescribed medication.
4. **I understand that I must bring the medication to school in a <u>properly labeled bottle</u> and will pick up any unused medication at the end of the school year or it will be disposed of on the last day of school. <u>Medication may not be transported by students or be transported on buses.</u>**
5. I give permission for the school nurse to consult with the above-named student's physician regarding any questions that arises with regard to the listed medication or medical condition being treated by this medication.

Signature of parent/guardian _____**Date** _____

Relationship to student _____Phone _____