



## Medication Authorization Form

This form must be filled out completely for school health staff to administer medication to a student. A new medication authorization form must be completed at the beginning of each school year, for each medication, and each time there is a change in the medication's administration instructions. The following is required by the provider of the medication according to Texas Education Code's, Chapter 22, Section 22.052:

- Prescription and non-prescription medication must be delivered to school in its original container.
- The container must be properly labeled by a pharmacist or the prescribing physician.

Student's Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Teacher/Homeroom: \_\_\_\_\_

Condition for which medication is being administered: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Times(s) of day to administer: \_\_\_\_\_

Medication shall be administered from: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Possible side effects: \_\_\_\_\_

Special requirements for administration/storage: \_\_\_\_\_

Known Food or Drug Allergies: YES ☐ NO ☐

If Yes, please explain: \_\_\_\_\_

Prescriber's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent /Guardian Authorization:** I request that school health staff administer the medication as described above by my child's primary prescriber. I consent to medication administration for my child named above and agree to review and provide any special instructions for the administration of child's medication and share that information with my child's school health staff.

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Cell Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Home Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_



## Self-Medication Authorization Form

The following must be provided to the school for a student to self-administer asthma or anaphylaxis medicine according to Texas Education Code, Chapter 38, Section 38.015:

- A written statement from the student's licensed healthcare provider that describes the student's medication and confirms their ability to self-administer their prescribed medication
- A written authorization signed by the parent for the student to self-administer the prescription while on school property or at a school related event or activity

### Prescriber's Authorization

Student's Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Teacher/Homeroom: \_\_\_\_\_

Condition for which medication is being administered: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time(s) of day to administer: \_\_\_\_\_

Is this a PRN, (As-needed) Medication? YES ☐ NO ☐

Medication shall be administered from: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

The student has demonstrated that they can self-administer their medication: YES ☐ NO ☐

If No, please explain: \_\_\_\_\_

Prescriber's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Authorization:** I request that school health staff allow my child to self-carry with the intention to self-administer the medication described above by my child's primary prescriber. I agree to notify the school nurse or school health staff and provide a new self-medication authorization form when there is a change in my child's medication, health status, or authorized healthcare provider.

Describe how your child will carry/store their medications:

\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_