Health Services
Crowley Independent School District

Medication Administration Authorization Form/Elementary- 2022 year

Date of Request: ______________ **School:** _________________________ **Allergies:** _________________

Student's Name: **DOB:**

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 parents in the 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 a 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 the 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: ______________________

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PARENT AUTHORIZATION

I ________________________ request that the above medication be administered to _____________________________________
(name of parent or guardian) (name of child)
by school personnel and give permission to speak with the physician if necessary for the care of my child.
I have received a copy of medication rules for CISD. _________________________________ **PH #:** ____________________

School Nurse: ___________________________ Clinic Phone#: __________________________________ Fax#: ______________
Nurse Signature after review: __________ Date received in clinic: ___________________________________