Montgomery I.S.D.

Authorization and permission for medication administration

Student's name _____DOB: _____

Teacher/Grade _____ID# _____School: _____

Received By: _____Date Received: _____

School Medication Policy: (For entire policy, please visit MISD website: www.misd.org)

- Physician's signature is required for any prescribed medication taken >14 days
- Parent signature and date authorized is required prior to administration of the medication
- All medication must be in the original container and cannot be expired
- Prescription medication must contain student name, name of medicine, directions and expiration date
- Medication changes: must be in writing and prescriptions require a new pharmacy bottle
- This form must be completed annually and all medication must be picked up prior to the last day of school

_____

Medication Dosage Time

_____

Medication Dosage Time

_____

Medication Dosage Time

Special Instructions/Allergies: _____

Other medications student is on: _____

Condition for which drug is to be given: _____

Physician's Name: _____**Telephone Number:** _____

Physician's Signature: _____ **START DATE:** _____

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and that **No student will carry or transport medication to and from school.**

Comments: _____

Parent/Guardian Signature: _____**Date**: _____

_____ _____

email address Daytime Telephone Number

STUDENT NAME: ____

Medication:			
Dose/Time:			
DATE:	Time:	Dose:	Initials:

Medication:			
Dose/Time:			
DATE:	Time:	Dose:	Initials:

Medication:			
Dose/Time:			
DATE:	Time:	Dose:	Initials:

Signature: ________________________________ Initials ________ Signature: __________________________________Initials: ________

Signature: ________________________________ Initials ________ Signature: __________________________________Initials: ________

Signature: ________________________________ Initials ________ Signature: __________________________________Initials _________