VIDOR INDEPENDENT SCHOOL DISTRICT

MEDICATION AUTHORIZATION FORM

STUDENT: _____DATE OF BIRTH:_____

TEACHER: _____GRADE:_____ID#:_____

*A MEDICATION CAN BE GIVEN DURING SCHOOL HOURS IF THE FOLLOWING CRITERIA ARE MET.

~~PARENT / GUARDIAN MUST BRING MEDICATION TO THE SCHOOL HEALTH OFFICE.

~~MEDICATION MUST BE IN THE ORIGINAL CONTAINER WITH LABEL.

~~MEDICATION AUTHORIZATION FORM MUST BE FILLED OUT AND SIGNED BY PARENT AND/OR PHYSICIAN.

*MEDICATIONS CAN ONLY BE GIVEN FOR A TOTAL OF 10 SCHOOL DAYS WITHOUT A PHYSICIANS SIGNATURE. AFTER 10 SCHOOL DAYS A PHYSICIANS SIGNATURE ON THE MEDICATION AUTHORIZATION FORM OR PRESCRIPTION PAD STATING IT IS NECESSARY TO GIVE MEDICATION DURING SCHOOL HOURS AS WELL AS THE ROUT, DOSE, TIME, FREQUENCY, AND DURATION OF THE MEDICATION. MEDICATIONS WILL BE DISPOSED OF 2 WEEKS AFTER LAST DAY OF AUTHORIZATION OR THE LAST DAY OF THE SCHOOL YEAR.

IN AN EFFORT TO PROMOTE STUDENT HEALTH AND MAINTAIN SCHOOL PERFORMANCE, IT IS NECESSARY THAT MEDICAITON BE GIVEN DURING SCHOOL HOURS.

NAME OF MEDICATION	DOSEAGE	TIME TO ADMIN	START DATE	STOP DATE	PHARMACY NAME	RX#
1._____	_____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____	_____

COMMENTS: (REASON FOR MEDICATION, POSSIBLE SIDE EFFECTS, ECT.)

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*** **PHYSICIAN SIGNATURE**: _____**DATE**:_____

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I HEREBY AUTHORIZE SCHOOL PERSONNEL TO ADMINISTER THE ABOVE MEDICATION TO MY CHILD DURING SCHOOL HOURS. ALSO, I AM AWARE THAT NO MEDICATION DOSAGE WILL BE CHANGED WITHOUT AN ORDER FROM THE PRESCRIBING PHSICIAN.

***PARENT/GUARDIAN SIGNATURE**: _____**DATE**:_____

TELEPHONE NUMBER: _____