AUSTIN Independent School District | Health Services

dell children's Ascension

AISD/Ascension Seton- School Health Services Medication Permit

Student Name: ________________________________ **Birth Date:** __________ **Student ID#** ______________

School Name: ___________________________________**Teacher:** _______________________ **Grade:** _______

Children's AISD Student Health Services and AISD require the following:

- **Only those medications that are medically necessary during school hours for a student's attendance or written in an IEP should be sent to school**
- A U.S. medical practitioner's written order/parent or guardian consent dated for the **CURRENT** school year and signed by the parent, legal guardian or other person(s) having legal authority of the student **AND** the medical practitioners who is licensed to practice medicine in the United States/State of Texas.
- Medication in the original, properly labeled container from a registered pharmacist (name of the student, name of the medicine with strength, dosage and directions; route to be given, name of prescribing physician who is licensed in Texas, and current date.
- Non-prescription/Over-the-counter medications require the above (AISD Student Handbook, FFAC Local)
- Students **ARE NOT ALLOWED** to carry any medication prescribed or over the counter, or to self-administer the medication unless ordered by the U.S. licensed medical practitioner. By law the only medications with a medical order/parent permission that may be carried by a student is an asthma inhaler, Epipen, and/or insulin/diabetes medication and supplies.

Please complete the following:

Medication Name and Strength (only one medication per page)	**Dosage**	**Time(s) to be Given at School**	**How it is Taken** (mouth, eye, ear, nose, tube, on the skin, etc.)	**Reason/ Medical Condition for which Medication is given**	**Medication expiration date** Expires:	**Additional Comments**

Medication Start Date:______________ Medication Stop Date: ________________* Good for the current school year 20 /20

Medical Provider's Name:______________________________**Signature:**_________________________**Date:**______________

Email:___________________________________ **Phone/Fax**__________________________________

(Note: the first dose of any medication may NOT be given at school)

Has the student ever received this medication before? Yes ____ No _____

*Yes, Date and Time last dose given ____________________________________

_____I request that the above medication be given during school hours as ordered by this student's physician. I also request that the medication be given on field trips, as prescribed with adequate notification from me.

2. I release school personnel from liability in the event adverse reactions result from taking the medication.
3. I will notify the school of any change in the medication, (dosage change, time change, etc.).
4. I give permission for the school nurse/ to communicate with the student's teachers about the student's health condition(s) and the action(s) of the medication.
5. I give permission for the school nurse to consult with the above student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by the medication.
6. I give permission for the medication to be given by trained school personnel as delegated by the Principal.

Parent/Guardian Printed Name:________________________ Signature:________________________________

Date: _______ Relationship: ______________________

Reviewed by RN_______________SHA __________may/ ________may NOT administer this medication

RN PRINTED Name: ____ RN Signature: ___________________

*Parent/Guardian/MD notified: (Date/Time)____________________________