Authorization to Administer Medication

Student Name: ___________________________ DOB: ______________ School Year: ___________________

School: _________________________________ Phone: __________________ Fax: _____________________

Parent/Guardian: _________________________ Cell: ____________________ Work: ___________________

Emergency Contact: _______________________ Phone: ___________________ Teacher/grade: __________

If a medication must be taken during school hours, UT Education Code 53-A-11-601 requires that a written authorization statement be on file. The statement must be signed by the parent/guardian and the physician indicating a desire that a designated school personnel assist the student with medication administration. Education Code requires that ALL medications, prescription AND over-the-counter must have a completed statement from BOTH the physician AND parent/guardian before they can be administered. Medication must be provided in the original container labeled with the students name, medication name, dose/strength and specific administration directions.

Parent/Guardian Authorization

As the parent/guardian of the above named child, I request that designated school personnel assist in the administration of medication prescribed by the physician. I give consent for the physician and School Nurse to communicate directly, regarding the administration of the medication. I understand the medication must be delivered to the school in a pharmacy labeled bottle with administration instructions that match the licensed health care provider's directions. I understand that this medication authorization form must be renewed annually or the beginning of each school year and/or when any part of the prescribed medication changes. I understand that the medication will be stored in a locked area unless the physician indicates that my child is capable of carrying and self-administering it (inhaler or epi-pen only).

Signature: ____ Date: ___________________

Physician Authorization

The following medications should be available for administration during the school day or during extended hours when the child is on school sponsored trips/outings/events.

Name of Medication	1.	2.	3.
Purpose of Medication			
Dose			
Administration Time or Frequency			
Potential Side Effects			
Can Student carry and self-administer medicine (inhaler/epi-pen only)	Yes/No	Yes/No	Yes/No

Physician Signature: ______________________________ Date: ________________ **rev 10/2015**