Mathis ISD **Health Services**	**Physician's Orders for** **Administration of Medication**

This Section to Be Completed by Medical Provider

Student' Name: _____ **DOB:** _____

Medication: _____ **Strength:** _____

Dosage: _____ **Frequency or Time/s to be administered at School:** _____

Start Date: _____ **Stop Date:** _____

Medical Condition for which medication is to be administered: _____

Allergies: _____ **Possible Adverse Reaction:** _____

Physician's Name: _____ **Physician's Signature:** _____

Date: _____ **Phone #:** _____

Physician's Comments: _____

MEDICATION POLICY AND PARENT/GUARDIAN CONSENT

- I request the above medication be given during school hours and I understand school personnel administering medication may not be medically licensed.
- I release school personnel from any liability in relation to this request when the medication is administered as ordered.
- I will **notify** the school of **any changes** in the medication, including providing updated physician's orders.
- I give permission for the school nurse to communicate with the teachers about the action and side effect of this medication.
- I give permission for the school nurse to consult with the student's physician regarding medication or medical condition for which the student is being treated. I also give permission for the school nurse to contact the pharmacy / pharmacist where medication is filled, for any clarification.
- **FIELD TRIPS**: I give permission for the assigned teacher or responsible adult to administer the medication on a field trip as necessary, following school protocol.
- Written permission(s) from the parent or legal guardian must be received **before** a medication is administered.
- **All** medication must be in the **original container** to include name of student, physician's name, medication name, amount and time to be given. **Please** ask for **TWO** labeled bottles from the pharmacy, school use and home.
- **Medication samples** from doctors **MUST** have a written doctor's orders with student's name, instructions and physician's signature.
- All Over the Counter (OTC) medication must have a physician's order to be administered and must come in **original** container. It will be administered as the label indicates, unless otherwise directed from the physician in writing.
- The initial dose of any medication must first be administered by parent. The school will not take responsibility for administering the initial dose to a student.
- **No aspirin products** will be administered by school personnel unless written orders are provided from a physician.
- **Controlled medications** must be brought into the clinic and picked up by a responsible adult**. DO NOT SEND CONTROLLED MEDICATIONS WITH YOUR CHILD** to school. This medication will **NOT** be sent home with the student. Some examples of controlled medications are; Adderall (Amphetamine Salts), Dexedrine, Tylenol w/Codeine, Hydrocodone (Vicodin), Ritalin (Methylphenidate), Concerta, etc. **PLEASE ask for TWO bottles from the pharmacy, one for school use and one for home.**
- No HERBAL / HOMEOPATHIC, non-FDA approved medications, or out of country medications will be administered by the school.
- ALL medications will be kept in the school health clinic for the exception of rescue medications such as rescue inhalers, epinephrine and insulin. These may be carried and self- administered by student with a current physician's order for self-administration.
- **Please Note: All medication not picked up by the last school day of this school year will be discarded.**

As the parent/guardian of child named above, I understand and will comply with this Medication Policy. I also understand that this medication will be discarded if not picked up by the last school day of this school year.

Parent/Guardian Printed Name: _____ **Signature:** _____

Contact Phone #'s: 1. _____ **2.** _____ **Date:** _____

Revised 06/02/20