Cleburne ISD Health Services

Medication Administration Authorization Form

Student: ________________________ DOB: ___________ School Year: _________________

CISD Campus: ___________________ Grade: ___________ Teacher: ___________________

***One <u>medication order</u> per medication form (Prescription and Over the Counter) <u>written</u> below by the Physician/PA/NP.**

Medication Name	Medication Dose/ Route	Medication Time to be given (ie: lunch)	Medication Duration

Physician/PA/NP Signature: _______________________________________Date:_________________

Physician/PA/NP Name: _______________________Office Phone: ______________________

** In accordance with the Nurse Practice Act, Texas Code Section 217.11 the school nurse has the responsibility and authority to clarify any medication order with appropriate licensed practitioner and/or refuse to administer medication that in the nurse's judgment is not in the best interest of the student.

Print Name of Staff receiving Medication with this form	Date Received	Medication Expiration	CISD Staff Signature

Campus RN reviewed the above medication on ____________ RN Signature _____________________

I give permission, as the parent/guardian of the above student, for my student to receive the medication as ordered above by a physician/PA/NP at school according to the Medication Administration Protocol and board policy.

___ **(parent/guardian initial)** * I have received a copy of the Medication Administration Protocol for CISD and by initialing, agree with CISD medication protocol/policies.

By signing this form, I release Cleburne ISD from any liability.

Parent/Guardian Signature: ___________________________________ Date: _______________________

Printed Parent/Guardian Name: _________________________________ Date: ________________________

Primary Contact Phone for Parent/Guardian: ____

STUDENT NAME:______________________________ MEDICATION:__________________

Date Reviewed												
DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY
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DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY

Signature:____________________ Signature:____________________ Signature:____________________

Charting Codes: A= Absent, DC= Discontinued, FT= Field Trip, OOM= Out of Medication, SF= Sent For

Date	#pills	office signature	parent signature	EXP	Date	#pills	office signature	parent signature	EXP