Medication Orders/Authorization/Consent

Student's Name: _____ **DOB:** _____ **Student ID#**_____ **Grade:** _____

Condition for which medication is given, side effects for child, special instructions, pertinent information:

_____

Allergies: _____

MEDICATION	DOSE/ ROUTE	START DATE	END DATE	FREQUENCY/ TIME TO BE GIVEN	1ST DOSE NEW MEDICATION?	*MAY GIVE A.M. DOSE
					☐Yes ☐No	
					☐Yes ☐No	
					☐Yes ☐No	
					☐Yes ☐No	
					☐Yes ☐No	

***Parent initial box above to indicate: Student may take morning (A.M.) dose of medication, if forgotten at home, with telephone permission from parent.**

·Parent-provided nonprescription medication from district-approved list may be given up to 10 times with no physician signature. All medications must be: unexpired; clearly labeled; and in the original, smallest container.

·Physician signature is **required** for off-label medications, medication samples and nonprescription medications that are not on the district-approved list.

·Herbal substances, dietary supplements, homeopathic or alternative medications lack safety information which limits their appropriate use at school. These medications will not be administered unless it has been determined educationally necessary as part of a student's IEP or §504 plan.

_____ (parent initials) **Changes in medication or dosage require a new physician signature/order. Any new or additional medication requests require a new form to be completed.**

_____ (parent initials) **Unused, discontinued or expired medication must be picked up by the parent. Medications not picked up will be disposed of at the end of the school year or within 5 days after discontinued.**

I request and authorize Rockwall ISD to administer the above medication(s). I understand that the school administrator may designate any qualified employee to administer this medication. I acknowledge that I understand the Student Handbook Medication Procedures. I authorize the school licensed nurse and prescribing healthcare provider to confidentially discuss or clarify this medication order, and to discuss the student's response to the medication as required by law (Nurse Practice and Medical Practice Acts of Texas).

_____ _____ _____ _____

(Parent/Guardian Signature) **(Print Name)** **(Date)** **(Phone)**

PHYSICIAN/HEALTHCARE PROVIDER

_____ (physician initials) *Additional orders/instructions for bronchodilator (specify):* _____*inhaled Dose:* ☐*2 puffs* ☐*4 puffs* ☐*ampule*. Repeat dose after _____minutes if symptoms persist or recur.

_____ (physician initials) *I have determined the off-label medication is necessary at school and further state that this medication has been clinically determined to be safe and effective based on this student's health needs.*

I request and authorize the above medication(s), dosage and frequency.

_____ _____ _____ _____

(Physician Signature) **(Print Name)** **(Date)** **(Phone)**

Request valid for one school year

Medication Orders/Authorization/Consent

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Reasons Dose Not Given			*comments/notes needed			
A	FT	H	R	ED	OOM	Waste
Absent	Field Trip	Hold*	Refused*	Early Dismissal	Out of Medication	Waste*

Medication Administration Record

Document doses administered by staff who are not Skyward Health Records users and wasted meds

Date	Time	Medication	Quantity administered/ route	Reason not given	Notes/comments	Admin by (signature)

Receive/Return Medication

Document witnessed pill count of all controlled medications received, returned to parent, or intra-district transfer to new campus (count at both sending and receiving campus). Witness: parent or RISD staff.

DATE	MEDICATION	DOSAGE	AMOUNT RECEIVED	AMOUNT RETURNED	EXPIRATION DATE	SIGNATURE	WITNESS SIGNATURE

Request valid for one school year