Seguin Independent School District HEALTH SERVICES	School Medication Administration Consent

Student:______________________ DOB:__________ ID#: ______________________

Teacher:__________________ GR:______ Room/Ext:____/____ SHARS: ______________________

MEDICATIONS			
I hereby request and authorize Seguin ISD personnel to give the following:			
MEDICATION(S)	DOSAGE	TIME	DURATION

Diagnosis/Medical Reason for medication: ______________________
____

Other medication(s) this student is taking: ______________________
____

Other recommendations/unusual side effects: ______________________
____
____

MEDICATION RECEIVED / PICKED UP / DISCARDED

Med(s) Rec'd Date:____________ Qty: ______
Received / Counted by: ______________________
Parent/Guardian: ______________________

Med(s) returned / date:____________ Qty: ______
Parent/Guardian: ______________________
Nurse / Aide: ______________________
Med discarded date:____________ Qty: ______
By: ______________ Witness: ______________

___ see additional med inventory, next page.

MEDICATION POLICY AND PARENT/GUARDIAN CONSENT

- I request that the above medication be given during school hours.
- I release school personnel from any liability in relation to this request when the medication is given as ordered.
- I will **notify** the school of **any changes** in the medication (dosage changed, or medication is discontinued)
- I give permission for the school nurse to communicate with the teacher's 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.
- **FIELD TRIPS**: I give permission for the assigned teacher or responsible adult to administer the medication on a field trip as necessary, following school procedure.
- Written permission(s) from the parent or legal guardian must be received **before** a medication can be given.
- **Al**l 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, one for school use and one for home.
- **Medication samples** from doctors **MUST** have a written doctor's orders with student's name, instructions and physician's signature.
- Non-prescription medications (over the counter – OTC) must come in **original** container. It will be administered as the label indicates, unless otherwise directed from the doctor in writing. After 10 days of use a note from the doctor is required.
- 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 by a doctor.
- **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 a student. **PLEASE, ask for TWO bottles from the pharmacy, one for school use and for one home.** Some examples of controlled medications are; Adderall (Amphetamine Salts), Dexedrine, Tylenol w/Codeine, Hydrocodone (Vicodin), Ritalin (Methylphenidate), Concerta, etc.
- No HERBAL / HOMEOPATHIC, non FDA approved medications, or out of country medications will be administered by the school.
- **PLEASE NOTE**: **All medications not picked up by the end of the school year will be discarded. It will be YOUR responsibility to see that this medication is picked up.**
- ALL medications will be kept under lock in the Nurse's clinic.

Parent/ Guardian Signature:______________________________ Date: ______________

Contact Phone #'s: 1.________________ 2.________________ 3 ________________

Revised 01/2020