Seguin INDEPENDENT SCHOOL DISTRICT

SCHOOL HEALTH SERVICES

exceptional students to exceptional citizens

MEDICATION CONSENT OTC / STM MEDS

MEDICATION PERMISSION REQUEST FORM (OTC/STM)

Student:_____ DOB: _____

School:_____ Grade:_____ ID#: _____

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

Diagnosis/Medical Reason for medication:_____

Other medications this student is taking: _____

Other recommendations/unusual side effects: _____

_____

MEDICATION POLICY & 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.
- **Medication samples** from doctors **MUST** have a written doctor's orders with student's name, instructions and physician's signature and in its original packaging.
- 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 first 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. Some examples of controlled medications are, Adderall, Dexedrin, Tylenol w/Codeine, Hydrocodone (Vicodin), Ritalin, Concerta, etc.
- HERBAL / HOMEOPATHIC, non FDA approved medications, must be prescribed by a Doctor and on a 504 plan.
- **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.**
- NO out of country medications will be accepted.

___see additional med inventory sheet

Parent/ Guardian Signature:_____ Date: _____

Revised 05-06-21

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MEDICATION PERMISSION REQUEST FORM (OTC/STM)

Student:_____ DOB: _____

School:_____ Grade:_____ ID#: _____

Teacher:_____ GR:_____ Room/Ext#:_____ # of Pills: _____

TO BE COMPLETED BY PARENT

Medication:_____ Strength:_____ Dose:_____ Time:_____

Reason for medication: _____

I, _____, give permission for my child to receive the above medication as directed. I also give permission for my child to be photographed for identification purposes only.

Parent/Guardian Signature:_____ Date: _____

Telephone: Home/Cell:_____ Work:_____

TO BE COMPLETED BY SCHOOL NURSE

	01	02	03	04	05	06	07	08	09	10
Day / Time										
Initials										

Medication START date: _____ (first day given)

Medication STOP date: _____ (expiration date – 10 days from start date)

Has medication changed to Long Term Medication: yes no (please circle)

Disposition of Medication: Continued Discontinued Hold (please circle)

Any medication to be returned: yes No (please circle) Amount returned:_____ School Nurse Initials: _____

Parent Signature:_____ Date: _____

School Nurse Signature:_____ Date: _____