



20____-20____
HIGHLAND PARK INDEPENDENT SCHOOL DISTRICT
MEDICATION ADMINISTRATION PERMISSION FORM

Campus: _____
Nurse: _____
Phone: _____
Fax: _____

Student's Name _____ GRADE _____ DOB _____ ID# _____ Wt. _____ lbs.

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

Medication Allergies: ☐ None _____

MEDICATION	STRENGTH (ex. 12mg)	DOSE/ ROUTE (ex.	START-END DATE	TIME TO BE GIVEN/FREQUENCY	1ST DOSE OF NEW MEDICATION	*MAY GIVE A.M. DOSE (INITIAL)
					YES ☐ NO ☐	
					YES ☐ NO ☐	
					YES ☐ NO ☐	

1. A Medication Administration Permission Form is valid for one year. Medication must be provided by the student's parent/guardian and must be in the original container with dosing instructions (no blister packs, Ziploc bag, or syringes)
2. Prescription medication must have a pharmacy label stating the child's name, medication, dose and instructions. Pharmacies will provide extra labeled bottle, if requested.
3. Physician signature is required for all medication given at school **and for self-carry inhalers or epinephrine auto injectors.**
4. 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.

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

I request and authorize Highland Park ISD to administer the above medication(s) as prescribed. I understand the school administrator may designate any qualified employee to administer this medication. I authorize the school licensed nurse and the prescribing healthcare provider to confidentially discuss or clarify this medication order, and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

(Parent/Guardian Signature)

(Printed Name)

(Date)

(Phone)

PHYSICIAN/HEALTHCARE PROVIDER

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

(Physician/Healthcare Provider signature)

(Printed Name)

(Date)

(Phone)

_____(physician initials) *I have instructed this student and give my permission for the self-carry of their emergency asthma and/or anaphylactic allergy medication. (check applicable)* ☐ inhaler (MDI) ☐ epinephrine auto-injector.

_____(physician initials) For severe breathing difficulty, emergency asthma medication (specify): _____ inhaled dose: ☐ 2 puffs ☐ 4 puffs ☐ ampule may be repeated _____ times _____ minutes apart.

_____(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.*

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

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

[illegible]

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 HPISD staff.

[illegible]