BHISD Health Services

Medication Orders/Authorization/Consent/Secondary

Name _____ DOB _____

School _____ School Nurse _____

Phone _____ Fax _____

Condition for which medication is to be given <u>at school:</u>

_____

A. Only medications that cannot be given outside the school hours will be administered. All medications must be in the original, properly labeled container.

B. All medications to be administered at school must be FDA approved. Supplements, home remedies, herbs, vitamins, homeopathics and other non-regulated substances will not be given.

Medication	Route	Dose	Frequency	Indication for use
1.				
2.				
3.				

Physician Signature _____ Print Name _____

Date _____ Office Number _____ Fax Number _____

Address _____

This form is valid for one school year. Physician/Dentist must be licensed to practice in Texas. Temporary (2 months) orders for out of state US physicians are acceptable to initiate treatment for transferring students. A signature is required for controlled substance, daily medications, or changes in the original prescription order.

I request and authorize the Barbers Hill ISD to administer the above medication as prescribed. I understand that the school administrator may designate any qualified person or persons to administer this medication.

Parent Please Initial:

_____ I **GIVE** permission for the school's RN and the prescribing physician to discuss and/or clarify this medication order or to discuss his/her response to the prescribed medication. This is required by the Nurse Practice & Medical Acts of Texas.

_____ I **DO NOT GIVE** permission for the RN to consult with my child's physician regarding medication order and/or response to this prescribed medication. I understand that the RN may not be able to administer the prescribed medication if the nurse believes that the inability to consult with the physician could compromise the safety of the student.

_____ **Unused medications not picked up within 5 days of being discontinued or at the end of the school year will be disposed of properly.**

PARENT/LEGAL GUARDIAN SIGNATURE _____

DAY TELEPHONE (S) _____ DATE _____

Med Expiration Date _____