# Cuero Independent School District
## -Health Services-

### ***Physician Authorization for Medication Administration at School***

(Please complete a form for each medication.)

When it is necessary for your child to receive medication during the school day:

- Parents/guardians must provide all medications and sign the Medication Administration Request form.
- All medication must be in the original container, clearly labeled with the student's name, the dosage, and directions for administration. Over the counter doses must not exceed the recommended doses and directions of the bottle unless accompanied by a physician's order.
- The Medication Administration Request form must be completed each year and when there are any changes to the original request. A separate form must be completed for each medication.
- Only FDA approved pharmaceuticals (prescription and non-prescriptions) manufactured with in the United States will be administered. Homeopathic preparations and allergy injections will not be accepted.
- A written physician's request is required for any medication administered longer than ten days.
- Sample medications from a physician must have written instructions from the physician.
- In the interest of safety for all students, medications must be transported to or from school by a parent/guardian.
- ANY change in your child's health condition needs to be reported to their campus nurse immediately.
- At the end of the school year, all medication that has not been picked up by a parent/guardian will be destroyed.

_____ _____ _____

Student Name Student Birthdate Campus

Name of medication to be administered:_____

Dosage:_____Route:_____Frequency:_____Time:_____

Diagnosis/Purpose of Medication:_____

Adverse Reactions:_____

Date of Discontinuation:_____

Special Instructions:_____

Physician Name: _____Phone#:_____Fax#:_____

_____ _____

Physician Signature Date

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### ***Parental Consent for Medication Administration at School***

My signature below, as the student's parent/guardian, indicates that I request that CISD staff administer the medication specified above to my child. The medication is furnished by me and is in its original container and the container is properly labeled. I am also giving my permission for CISD staff to contact the physician for additional information, if needed.

_____ _____ _____

Parent/Guardian Signature Phone number Date