Lockhart ISD Student Health Services
Authorization for Medication Administration during the School Day
2022-2023 School Year

Student Name: _____Birth Date: _____

School Name: _____ Teacher: _____ Grade: _____

Student's Physician: _____Phone: _____Fax: _____

Medication Allergies: ☐ No Known Drug Allergies ☐ Allergic to:_____

Medication requested to administer: _____ Dosage: _____

Directions: _____

Has the child ever taken this medication before? ☐ Yes ☐ No (All first doses of medications must be administered at home)

Parent Authorization:

When it is necessary for your child to receive medication during the day, the following must be followed:

- All medication must be in the original container and provided by the parent(s) or guardian(s).
- Prescription medication will be administered as per prescription label/physician's order. Nonprescription medication will be administered as per label on bottle. Any deviation from dosage instructions on bottle requires a doctor's order.
- Nonprescription medication may be administered for of up to 5 days. A written request by a physician shall be required when the medication must be administered for a longer period.

I authorize the physician named below to release information to Lockhart ISD Health Services regarding medication(s) that my child will take during school hours. I request that the campus nurse or trained designated staff administer medication to my child per physician's order/medication bottle. I authorize Health Services staff to exchange information with the physician regarding medication and health related issues. I understand that it is my personal responsibility to furnish an adequate supply of this medication in the original and properly labeled container. I will notify the school immediately if the health status of my child changes, if there is a change of physician, or if the medication is changed or cancelled. No more than a 30-day supply of medication should be kept on campus. At the end of the school year, all medication not picked up by the parent/guardian will be destroyed.

Parent Printed Name: _____Phone:_____

Parent Signature: _____Date:_____

Physician Authorization: Please be sure to provide action plans for seizures, asthma, and severe allergies.

Medication Allergies: ☐ NKDA ☐ Allergic to:_____

Medication: _____ Dose (mg not tablets):_____ Route:_____

Administration Instructions: Time(s)_____ Dates_____ OR ☐ Entire School Year

Condition for which the medication is required: _____

If PRN, describe indication: _____ May repeat PRN dose after: _____

Special Instructions or known side effects of medication:_____

I verify the above medication information is accurate and needs to be administered during school hours for the student listed.
Student is authorized to self-carry and self-medicate (inhalers, epi-pens, and diabetes care) ☐ Yes ☐ No

Physician's Name:_____ Signature:_____ Date:_____