2014-15

WYLIE INDEPENDENT SCHOOL DISTRICT
Medication Order/Authorization/Consent

Student's Name: ______________________________ **DOB:** _________ **Allergies:** ________________________

Date of Request: ______________ **School:** __________________ **Teacher/Grade:** ________________________

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

____

MEDICATION	DOSE	START DATE & END DATE	INITIAL DOSE OF NEW MEDICATION?	TIME(S) TO BE GIVEN AT SCHOOL
1.			YES☐ NO☐	
2.			YES☐ NO☐	
3.			YES☐ NO☐	

Physician's Signature: ________________________________ **Print Name:** ______________________________

Office Phone:______________________________ **Fax Number:** ______________________________________

☐ **Student may take morning dose of medication, if forgotten at home, with telephone permission from parent.**

Valid for one year. Physician signature is **required** for all controlled substances, off-label medications and medications containing aspirin (aspirin-containing medications will not be administered to students under the age of 12). Over-the-counter medication will be given for no more than one school week. After that an order from the student's physician may be required. All medication must in an original, properly labeled container and not expired.

I request and authorize Wylie ISD to administer the above medication(s) as prescribed. I understand that the school administrator may designate any qualified employee to administer this medication. I authorize the registered nurse and the prescribing physician (print name) ____________________ to confidentially discuss or clarify this medication order, and to discuss the student's _______________________ (print name) response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

Parent/Guardian Signature: ______________________________________ **Date:** _________________________

Telephone(s): _______________________________________ **Email:** ________________________________

FOR OFFICE USE ONLY

Medication Count:

Date	# Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials

Comments (Indicated by * on back of form):

Date	Comments	Date	Comments

Date	RN Review

Signature/Initials of Person Administering Medication or Counting

_________________________________/_______ _________________________________/_______

_________________________________/_______ _________________________________/_______

Rev