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

**2021-22**

**WYLIE INDEPENDENT SCHOOL DISTRICT**
**MEDICATION ADMINISTRATION PERMISSION FORM**

**Student's Name_____ 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 | |

*Parent initial box above to indicate: Student may take morning (A.M) dose of medication, if forgotten at home, with telephone/written permission from parent.

- 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 dosing syringe)
- Prescription medication must have a pharmacy label stating the child's name, medication, dose and instructions. Pharmacies will provide extra labeled bottle if requested.
- A *Medication Administration Permission Form* for over-the-counter medications is valid for 5 days without physician consent.
- Physician signature is required for off-label medications, medication samples and nonprescription medications that are to be given longer than 5 days **OR for self-carry inhalers or epinephrine auto injectors.**
- 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. Any new or additional medication requests require a new form to be completed.

____**(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 Wylie 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***

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

_____

(Physician/Healthcare Provider) (Printed Name) (Date) (Phone)

**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

| Date | Time | Medication | Quantity administered/ route | Reason not given | Notes/comments | Admin by (signature) |
|---|---|---|---|---|---|---|
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## 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 WISD staff.

| DATE | MEDICATION | DOSAGE | AMOUNT RECEIVED | AMOUNT RETURNED | EXPIRATION DATE | SIGNATURE | WITNESS SIGNATURE |
|---|---|---|---|---|---|---|---|
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