"Changing lives with high quality educational experiences and a strong foundation of academic excellence."

Daily Medication Administration Form

Student's Name:___________________________ Date of Birth:_______________Grade:_______Teacher:______________

Parent's Names/ Phone Numbers:

Mom/Guardian 1:________________________ Dad/Guardian 2: _________________________

_____-_____-_______ _____-_____-_______

Physician Information:

Physician Name:____________________________ Phone #: _______-_______-___________

- I request and authorize that school personnel administer this medication/procedure at school.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle for school from pharmacy.)
- I understand that any daily medications that are due before 9 A.M. must be given by the parent before the start of school.
- This order is in effect for this school year only.
- I will obtain a new, signed, physician's order and notify the school in writing for any changes.
- I authorize the school nurse to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I further understand that all medication is to be transported to and from school by parent/guardian.
- I understand that non-medically licensed school personnel will give medication if the school nurse is unavailable at the ordered time.
- I agree to hold School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.
- **ASTHMA INHALERS AND EPI-PENS/AUVI-Q's ONLY:** This student is capable of self-administration and may carry inhaler or EPI pen and self -administer in school: **YES** **NO**

______________________________________ ______________________

Signature of Parent/Guardian Date

High Point Academy
1256 Jim Wright Freeway
Fort Worth, Texas 76108
817.600.6401

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Daily Medication/Procedure:

Name of Medication or Procedure: ___________________________Dose/Directions (as stated on bottle):_________________

Reason for medication/procedure (diagnosis):____

Method (circle one): Oral Inhaled Nebulized Injection Topical Eye Ear Other (specify):_____________________

Time to be given: ____ Dose:__________________________________

Dates to be given (If not daily. Ie: Tues, Thurs, etc):____

Administer (circle one): Daily As Needed (PRN)

If medication is to be administered on an as needed (PRN) basis, state conditions under which medication is to be given:

____

____Additio nal Directions:

____

Precautions/Unfavorable Reactions:____

____

PHYSICIAN ORDER: (required for all Prescription Medication/Food supplements or natural products; or over-the-counter medication that exceeds the recommended packaging dose.)

ASTHMA INHALERS AND EPI-PENS/AUVI-Q's ONLY: This student and his/her parents/guardians have been instructed in self-administration and this student may carry an inhaler or EPI-PEN/AUVI-Q and self-administer in school**.** **YES** **NO**

The above medication is to be administered during the school day in accordance with the above instruction and agreements. I agree to accept communication about student/medication and understand that non-medically trained school personnel may give the medication on occasion.

____ _________________________

Signature of Physician/Practitioner Date

____ ________-________-_________

Printed Name of Physician/Practitioner Physician Phone Number

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