Sulphur Springs Independent School District
631 Connally Street
Sulphur Springs, Texas 75482
903-885-2153
www.ssisd.net

Authorization to Administer Medication at School

Prescription and non-prescription medications to be administered at school ***must*** be delivered to school in the ***original container and properly labeled***:

- Non-prescription: student name written on original container/packaging.
- Prescription: student name and dosing instructions affixed to original bottle/packaging from the pharmacist or prescribing physician.

The following information must be provided, by the parent/legal guardian, for each medication to be administered, and each time there is a change in the medication's administration instructions :

Student Name: ____
(Legal First, Last)

Date of Birth: _____ /_____ /_____

Condition for which medication is being administered: ____

Medication Name: ____________________________________

Dose: ____________________ **Route:** ___________________

Prescriber's Name: _______________________________

Medication shall be administered from:

Start Date: _____ / _____ / _____ **Stop Date:** _____ / _____ / _____

Time(s) of day to administer: ____

Potential side effects: ____

Special requirements for administration/storage:

Food or drug Allergies: □ **Yes** **or** □ **No**

If Yes, please explain:

[TEC, Ch 22, Sec 22.052]

(Continued on next page)

_____ INITIAL — Only those medications that are medically necessary during school hours for a student's attendance or written in an IEP should be sent to school.

_____ INITIAL — School personnel are not responsible for any ill effects that might occur from this medication.

_____ INITIAL — Medication (non-prescription and prescription) must be in the original container/packaging/bottle and properly labeled with student's name and dosing instructions affixed from the pharmacist or prescribing physician.

_____ INITIAL — Persons who may assist your child with medications at school include the school nurse (RN or LVN) and/or a trained campus staff member.

_____ INITIAL — For prescription medication to be given at home and at school, ask your pharmacist to prepare two labeled containers, one for home and one for school.

_____ INITIAL — Over the counter (OTC) medications needed longer than two weeks must have a review and approval of the school nurse AND may require a physician's order.

_____ INITIAL — The very first dose of a prescription medication for a current condition/illness WILL NOT be given at school.

Parent /Guardian Authorization to Administer Medication at School

I authorize school staff administer the medication, as described above, and prescribed by my child's physician and agree to review and provide/share any special instructions for the administration of the medication with school staff.

Parent/Guardian Signature: ____

Date: _____ / _____ / _____

Relationship to student: ____

Phone (_____) - _____ - __________

To be completed by school staff:

Medication received by: ____ Date: ____/____ /_____

Initial Count (pills/tablets): _____ Initial Measurement (liquids) _____

For controlled substances only:

Witness: ____ Date: ____/____ /_____