North Zulch ISD

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NURSING SERVICES MEDICATION AUTHORIZATION FORM

1. Only medications MUST be in ORIGINAL, PROPERLY LABELED containers dated for the current school year and brought to school by an adult. Medications must be age appropriate.
2. Medications sent in baggies or unlabeled containers WILL NOT BE GIVEN and will be destroyed. All prescription medication must be provided in a container with the pharmacist's label attached. Non-prescription OTC (over-the-counter) medication must be in the container with the manufacturer's original label. Physician samples must be appropriately labeled BY THE PHYSICIAN with the patient's name and instructions.
3. The first-day dosage of any medication must have been given at home BEFORE it can be administered at school.
4. An emergency plan for anaphylaxis, seizure, asthma, and diabetes, in the addition to Medication Authorization Form is required for self-carry/self-administered emergency medications, such as inhalers/EpiPens/Insulin.
5. FDA-approved OTC medication may NOT be given by the campus nurse without a doctor's written prescription.
6. Morning medications need to be given at home prior to school. Exceptions to this will be evaluated on an individual basis by the campus nurse.

MEDICATION ADMINISTRATION AT SCHOOL

Student:_____ Known Allergies:_____
Date:_____ DOB:_____ Grade/Teacher:_____
(Form is valid for the current school year, including summer sessions)

MEDICATION	DOSE	ROUTE	FREQUENCY	RATIONALE	PARENT INITIAL/ NURSE INITIAL

PARENT/GUARDIAN CONSENT:

- I give my permission for the above medication(s) to be given to my child at school or on school-sponsored field trips according to the above requirements.
- I understand that the medication may be given by an authorized NZISD employee in the absence of the RN/LVN
- I understand that medication will be destroyed unless picked up by the end of the last day of classes.
- I give permission for my child to transport the above medication(s) home. I accept responsibility for my child and the specific medication. I understand controlled medications will not be sent home with the student.
- I authorize the school nurse to communicate with our healthcare provider: _____ as allowed by HIPAA.
- I authorize the school to disclose the above information to those within the school district that has a need to know for educational purposes.

Parent/Guardian Signature:_____ Date:_____ Relationship to student:_____
Contact Phone:_____ Email:_____
Medication pick up (Date):_____ Signature:_____
Medication wasted (Date):_____ Signature:_____

RIGHT patient, **RIGHT** medication, **RIGHT** dose, **RIGHT** route, **RIGHT** documentation, **RIGHT** reason, **RIGHT** reason, **RIGHT** response…**EVERY TIME!**