



May Independent School District

Where everybody is somebody

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HS Principal

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Dear Parent or Guardian:

To comply with the school districts medication administration policy and Texas State Law, please review and provide the following information for medication administration:

1. All medication must be brought to school and kept in the school nurse office in a locked storage unit.
2. Both prescription and non-prescription medications must be brought to the school in their original, properly labeled container. Prescription medication must contain a current pharmacy label.
3. A medication authorization form must be signed for all medications that are to be administered to the student.
4. School personnel will not give any medicine, including over the counter medications and products, to students except as authorized by district policy and with a signed medication authorization form.

This policy is necessary to protect the health and safety of your child. We appreciate your cooperation in this matter for those reasons.

Sincerely,

Rachel Beal, LVN

(254) 259-3711

**Please keep a copy of this form for future use, in case your child should need to take medication during school.*

This form must be filled out completely in order for school health staff to administer medication to a student. A new medication authorization form must be completed at the beginning of each school year, for each medication, and each time there is a change in the medication's administration instructions. The following is required by the provider of the medication according to Texas Education Code's, Chapter 22, Section 22.052:

- Prescription and non-prescription medication must be delivered to school in its original container.
- The container must be properly labeled by a pharmacist or the prescribing physician.

Student's Name _____ Sex _____

Date of Birth ____ / ____ / ____ Grade _____ Teacher/Homeroom _____

Condition for which medication is being administered _____

Medication Name _____ Dose _____ Route _____

Times(s) of day to administer _____

Medication shall be administered from ____ / ____ / ____ to ____ / ____ / ____

Possible side effects _____

Special requirements for administration/storage _____

Known Food or Drug Allergies ____ YES ____ NO

If YES, please explain _____

Prescriber's Name _____ Telephone ____ - ____ - ____

Address _____

Prescriber's Signature _____ Date _____