NORTH ZULCH ISD
NON-PRESCRIPTION MEDICATION AUTHORIZATION FORM

Note: This form should not be used for diabetes, seizure, asthma, or anaphylaxis medications.

Only medications that are required to enable a student to stay in school may be given at school. Three times a day medication should be given before school, after school, and at bedtime. If necessary, medication can be given at school under the following conditions:

1. Non-prescription or over-the-counter medication (including cough drops) must be brought in by an adult in the original container with the label intact and non-expired. **MEDICATION SENT IN BAGGIES OR UNLABELED CONTAINERS WILL NOT BE GIVEN AND WILL BE DESTROYED.**
2. All medications need a physician signature and a parent/guardian signature. Any change in dosing will require a new order accompanied by physician signature and parent/guardian signature. NO MEDICATION WILL BE GIVEN WITHOUT A PARENT/GUARDIAN AND PHYSICIAN SIGNATURE.
3. Medication prescribed or requested to be given three times a day or less will not be given at school unless a specific time of administration during school hours is prescribed by a physician.
4. **The initial dose of any medication new to the student must be given at home to observe for adverse reactions before it can be administered at school.**

NON-PRESCRIPTION MEDICATION ADMINISTRATION AT SCHOOL

Student _____ Date _____ Grade _____ School Year _____

Known Allergies: _____

(Form is valid for the current school year, including summer session)

Medication	Dose	Route	Time to be given or Interval	Indications

Physician Name (Printed)	Address	Phone Number

Physician Signature* Date

***If orders for non-prescription medication use are included on an Action Plan signed by a physician, attach a copy of the Action Plan to this page in lieu of this physician signature.**

PARENT/GUARDIAN CONSENT:

- I request that designated personnel of NZISD administer the medication listed to my child according to physician instructions.
- I understand that NZISD personnel will not administer medication if this form is not completed or the medication is not furnished as required.
- I understand that the Board, the School District, and its employees shall be immune from civil liability due to allergic reactions or other injuries resulting from the administration of medication to my child, provided such administration conforms to the requirement of this policy.
- I understand that the Nursing Practice Act and Texas Administrative Code §217.11 (D)(vi) compels the RN or LVN to contact other health care team members, including the prescribing physician, concerning significant events regarding the patient's status.

Check one: ▢ I will pick up medication at the end of the year.
▢ Please dispose of medication at the end of the year.

Parent/Guardian signature Date Relationship to student

Home Phone Number Work Phone Number Cell Phone Number

******In accordance with the Nurse Practice Act; Texas Administrative Code, Section 217.11, the Registered Nurse and the Licensed Vocational Nurse have the responsibility and authority to refuse to administer medications that, in the nurse's judgment, are contraindicated for administration to the student.******

FOR CLINIC USE ONLY: ▢ Entered in School ▢Teacher notified ___/____ ▢ IHP (if applicable)

Medication Count:

Date	Count	Nurse signature	Parent/Witness signature	Date	Count	Nurse Signature	Parent/Witness signature

Comments:

Date	Comment	Date	Comment

Date Reviewed:	**RN Printed Name**	**RN Signature/Initials**