HALLSVILLE INDEPENDENT SCHOOL DISTRICT
STUDENT MEDICATION ADMINISTRATION FORM

phone: 903-668-5990 fax: 903-668-5991

Grade

The parent/guardian of _____ ask that school/child care staff give the
(Child's name)

following medication _____ at _____
(Name of medicine and dosage) (Time(s))

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer medication prescribed by a licensed health care provider.
It is the parent/guardian's responsibility to furnish the medication.
The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Work Phone Home Phone

****

Health Care Provider Authorization to Administer Medication in School

**only valid if complete*

Child's Name: _____ Birthdate: _____

Medication: _____

Dosage: _____ Route _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

Starting Date: _____ Ending Date: _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority License Number

_____ _____
Phone Number Date

****

_____
HISD Nurse Signature Medication Count Date Received

THIS FORM IS VALID FOR CURRENT SCHOOL YEAR ONLY

Date:_______________________________ Date:_______________________________

Med. count:__________________________ Med. count:__________________________

Nurse staff sign:_____________________ Nurse staff sign:_____________________

Parent sign:_________________________ Parent sign:_________________________

Date:_______________________________ Date:_______________________________

Med. count:__________________________ Med. count:__________________________

Nurse staff sign:_____________________ Nurse staff sign:_____________________

Parent sign:_________________________ Parent sign:_________________________

Date:_______________________________ Date:_______________________________

Med. count:__________________________ Med. count:__________________________

Nurse staff sign:_____________________ Nurse staff sign:_____________________

Parent sign:_________________________ Parent sign:_________________________

Date:_______________________________ Date:_______________________________

Med. count:__________________________ Med. count:__________________________

Nurse staff sign:_____________________ Nurse staff sign:_____________________

Parent sign:_________________________ Parent sign:_________________________

Date:_______________________________ Date:_______________________________

Med. count:__________________________ Med. count:__________________________

Nurse staff sign:_____________________ Nurse staff sign:_____________________

Parent sign:_________________________ Parent sign:_________________________

—--MEDICATION SIGN OUT—---

Date:____

Nurse staff signature:____________________________

Parent signature:_______________________________