LISD Health Services
Medication Orders/Authorization/Consent

Name ______________________DOB _______ School: **FORESTWOOD MS** Teacher/Grade_____

School Phone: **469/713-5972** Fax: **972/350-9184** School Nurse: **Jane DeGiulio, RN, BSN**

Condition for which medication is to be given at school and administration instructions:

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Only medications that cannot be given outside the school hours will be administered. All medications must be in the original, properly labeled container.

Medication	Route	Dose in mgs.	Times/Indications for use
1.			
2.			
3.			

Physician Signature__________________________________ Print Name____________________

Office Number __________________________ Fax Number ______________________________

Valid for one school year. Physician/Dentist must be licensed to practice in Texas. Temporary (two months) orders from out-of-state US Physicians are acceptable to initiate treatment for trans ferring students. A signature is required for controlled substances, daily, or PRN therapy lasting over 15 days or changes in the original prescription order.

I request and authorize the Lewisville ISD to administer the above medication as prescribed. I understand that the school administrator may designate any qualified person or persons to administer this medication. I also understand that although a reasonable attempt will be made to remind the student, it is expected that the student will be responsible in most situations for remembering to visit the health room for his medicine.

I authorize the school's registered nurse and the prescribing physician (print name) ____________________ _________________________to discuss this medication order, to clarify this medication order, or in the interest of this student's health(print name of student) ___________________________, to discuss his/her response to the prescribed medication as required by Nurse Practice Act and Medical Practice Acts of Texas. If the consent for the nurse and the doctor to consult regarding this medication order is not granted or is revoked, it may not be possible for school personnel to administer the prescribed medications**.**

Elementary students are not permitted to transport medications. Unused medications not picked up at the end of the school year will be disposed of properly. ___________
Parent initials

For Middle School and High School Students ONLY (parent please initial):

________I **GIVE** permission for the school to allow my child to transport medication and equipment to and from school.

________I **DO NOT GIVE** permission for the school to allow my child to transport medication and equipment to and from school. The medication will always be picked up or delivered by a parent/guardian or designated adult.

PARENT/LEGAL GUARDIAN SIGNATURE__________________________________

DAY TELEPHONE (S) ________________________________DATE_______________