LISD Health Services

Medication Orders/Authorization/Consent/Secondary

Name ________________________________DOB_____________ID Number___________________

School ____________________________ School Nurse ___________________________

Phone ______________________________ Fax ____________________________

Condition for which medication is to be given at school and administration instructions:
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A. ***Only medications that cannot be given outside the school hours will be administered. All medications must be in the original, properly labeled container.***
B. ***All medications to be administered at school must be FDA approved. Supplements, home remedies, herbs, vitamins, homeopathics and other non-regulated substances will not be given.***

Medication	Route	Dose in mgs	Frequency	Indication for use
1.				
2.				
3.				

Physician Signature_________________________________ Print Name__________________________

Date___________ Office Number ____________________ Fax Number ______________________

Address____

This form is valid for one school year. Physician/Dentist must be licensed to practice in Texas. Temporary (2 months) orders for out of state US Physicians are acceptable to initiate treatment for transferring students. A signature is required for controlled substances, daily or PRN therapy lasting over 5 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/her medicine.

I authorize the school's registered nurse and the prescribing physician to discuss and/or clarify this medication order or in the interest of this student's health, to discuss his/her response to the prescribed medication as required by the 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**.**

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 be picked up or delivered by a parent/guardian or designated adult.

PARENT/LEGAL GUARDIAN SIGNATURE____

DAY TELEPHONE (S) ___________________________________ DATE_______________

Med Expiration Date ______________________________

2015-2016