

MARION INDEPENDENT SCHOOL DISTRICT

Student Personnel

Series 500

Policy Title ADMINISTRATION OF MEDICATION TO STUDENTS

Medication Administration Authorization

To ensure compliance with the Board Policy for Medication Administration, the following **MUST** be completed:

- Parents have completed and signed the Medication Administration Authorization form for all prescribed or over-the-counter medication.
- The medication is in the original, labeled container as dispensed by the pharmacy or as bought in the manufacturer's labeled container.
- The medication label contains the student's name, name of medication, dosage, directions for use, and date.
- Authorization is renewed annually and immediately when the parent notifies the school that changes are necessary.

Student name _____ Birth date _____

School _____ Teacher/Grade _____

Name of Medication _____ Dosage _____

Route (by mouth, etc.) _____ Time to be given _____

Reason for Medication _____

Possible Side effects/special instructions _____

Physician Name _____ Physician Phone _____

Start Date _____ Stop/reevaluate Date _____

I request the above student receive the above medication at school and at school activities, according to the prescription and instructions. I understand the school will keep a written record. This information is confidential except as stated in the Family Education Rights and Privacy Act (FERPA). I agree to coordinate and work with the school personnel and the physician when questions arise. I agree to provide safe delivery of the medication and the equipment to and from school and to pick up the remaining medication/equipment.

Parent Signature _____ Date _____

Parent's address _____ Phone _____

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**Additional Authorization for medication prescribed for
ADD/ADHD:**

Student name _____ Grade _____

Birthdate _____

I give permission to the Marion Independent School District to complete Behavior Checklists to help monitor medication administered to the above named student. I understand the checklists will be completed at least twice a year and two weeks after any dosage changes. I request the checklists be sent to the following physician and me.

Physician _____

Address _____

Phone _____

This permission is good for one year from the date signed below. I may cancel permission by giving written notice to the Marion Independent School District and the physician listed above.

Parent Signature _____ Date _____

Medication/Dosage to be monitored _____

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Policy Title ADMINISTRATION OF MEDICATION TO STUDENTS Code No. 504-1-E2

**Marion Independent School District
Authorization for Student's to Self Administer
Asthma Medication**

Student _____ **Birthdate** _____

School _____ **Start Date** _____

- I request the above student possess and self-administer Asthma medication at school and during school activities according to the authorizations and instructions.
- I understand the school district and its employees acting reasonably and in good faith shall incur no liability for any improper use of this medication or for supervising, monitoring, or interfering with a student's self-administration of this medication.
- I agree to coordinate and work with school personnel and notify them when questions arise or relevant conditions change.
- I agree that I/my child will assume full responsibility for safe delivery/use/monitoring of this medication.
- I agree this information will be shared with school personnel in accordance with the Family Education Rights and Privacy Act (FERPA).
- If needed, I agree to provide the school with back-up medication approved in this form.

Parent Signature _____ **Date** _____

Parent Daytime Phone _____

I request that the above named student be allowed to carry and self-administer his/her Asthma medication.

Physician Signature _____ **Date** _____