Montgomery ISD
Authorization and Permission for Administration of Medication

STUDENT'S NAME _____ **DOB** _____
Last First Middle

Teacher/Grade _____ Date _____ Received by _____

School Name _____ ID# _____

General Guidelines:

(1) Any prescription being taken>14 days requires physician's signature.
(2) Parent signed, dated authorization to administer the medication.
(3) The medicine is in the original container as dispensed or the manufacturer's labeled container.
(4) The medication label contains the student name, name of the medication, directions for use and date.
(5) Annual renewal of authorization and immediate notification, in writing, of changes.

_____
Medication Dosage Time

_____
Medication Dosage Time

_____
Medication Dosage Time

Special Instructions _____

Allergies _____

Condition for which drug is to be given _____

Other medications student on _____

PHYSICIAN'S NAME (print) _____ **signature** _____

PHONE NUMBER _____ **START DATE** _____

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and pick up remaining medication and equipment or it will be properly destroyed. **I understand that no student will transport medication to or from school.**

Comments: _____

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PARENT'S SIGNATURE **DATE** **DAYTIME PHONE**