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Note: Sample medication logs can be found in Chapter 5 of the Texas Department of State Health Services *Texas Guide to School Health Programs* at http://www.dshs.state.tx.us/schoolhealth/shpguide/chap5.pdf.

Exhibit A—Request for the Administration of Medication at School

Date form was received by the school:________________

Student name: ______________________________ Date of birth or age: ___________

Grade: ______ Teacher/Classroom: ________________

Name of medication: ____

Reason for medication: ____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer

☐ Other ________________________________

Instructions: (Schedule and dose to be given at school): ________________
____

Start: ☐ Date form received ☐ Other date: ________________

Stop: ☐ End of school year ☐ Other date: ________________

Restrictions and/or important side effects:

☐ None Anticipated

☐ Yes. Please describe: ____
____

Special storage instructions:

☐ None ☐ Refrigerate ☐ Other: ________________

Physician Information:

Name: ____

Address: ____

Phone Number: ________________________________

Physician Signature____ Date ________

To be completed by parent/guardian:

I give permission for ________________________________ *(name of child)* to receive the above medication at school in accordance with Department policy [See FFAC]

Parent/Guardian Signature ____ Date ______

[Developed using resources from the American Academy of Pediatrics and Texas Department of State Health Services]

Exhibit B—Authorization to Secure Emergency Medical Treatment of a Student

Name of student ____ Grade __________

Date of birth _____________/___________/_____________

Parents' names ____

Work phone ______________________ Home phone _________________________

Work phone ______________________ Home phone _________________________

Address ____

Friend or relative who may know where to locate a parent

Name ____

Phone ____

Student's physician or other preferred health-care provider

Name ____

Phone ____

Student's dentist

Name ____

Phone ____

Medications or drugs to which the student has had an allergic or adverse reaction:

____

____

____

I hereby authorize the Superintendent of ____________________________ SD or a designated representative to secure any and all emergency medical care and treatment for ________________________ *(student's name)* for acute illness suffered or injury sustained while at school or participating in school-related activities. I prefer that emergency treatment be secured at ______________________________ *(indicate preferred medical facility)*; the Department may use another licensed hospital, clinic, or medical facility, if necessary, with the following exceptions: ____.

I understand that cost of services provided by ambulance, private physician, clinic, hospital, or dentist remains the responsibility of the parent or guardian and will not be assumed by the Department or any of its officers or employees.

I ☐ do not have ☐ do have medical insurance coverage on my child with
____ Insurance Company.

Parent's signature _______________________________________Date ___________

Copies of this authorization may be presented to the admissions office of a hospital or clinic or to a physician or dentist. Other distribution will occur only within the limitations of the Family Educational Rights and Privacy Act.

Exhibit C—Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication

Name of student ____ Grade _____________

Name of parent ____

Parent's contact information ____

Prescribing health-care provider ____

Contact information for the prescribing health-care provider _______________________

____

Description of condition/reason for medication ___________________________________

____

Prescribed medication and dosage ____

How/when the medication should be used at school *(dosage, method, times)* ____________

____

Anticipated length of treatment ____

Possible adverse reaction ____

____________________________________ *(student's name)* has asthma and/or anaphylaxis and is treated with prescription medication. *(He)(She)* is capable of administering *(his)(her)* own medication at school and at school-related or school-sponsored activities. The Department will be informed of any changes to the medication specified on this form, to the dosage, or to the recommended regimen by an updated version of this consent form.

Parent ____ Date _____________

Health-care provider ______________________________________ Date _____________