Request for Administration of Medication at Harvest Christian Academy

This form must be filled out completely for school health staff to administer medication to a student. A new medication authorization form must be completed at the beginning of each school year, for each medication, and each time there is a change in the medication's administration instructions. The following is required by the provider of the medication according to Texas Education Code's, Chapter 22, Section 22.052:

- Prescription medication must be delivered to school by an adult in its original container and must be properly labeled by a pharmacist or the prescribing physician.
- Non-prescription medication must be in its original container and may not be given longer than 10 days without a physician's written order.

Student's Name: _____

Date of Birth: _____ /_____/_____ Grade level: _____

Medical condition for the medication being administered:
_____

Medication Name: _____ Dose: _____ Route: _____

Times(s) of day to administer:
_____

Dates medication shall be administered from: ___/____/_____ to: _____/____/_____

Possible side effects:
_____

Special requirements for administration/storage (if required):
_____

Known Food or Drug Allergies: YES ___ NO ___

If YES, please explain: _____

Physician Authorization (for prescription medication):

Prescribing Physician's Name: _____

Phone: _____ - _____ - _____ Address: _____

Physician's Signature (REQUIRED)**:** _____

Date: _____

Parent /Guardian Authorization:

I request that school health staff administer the medication as described above by my child's physician. I consent to medication administration for my child named above and agree to review and provide any special instructions for the administration of child's medication and share that information with my child's school health staff. I understand that the medication may be given by an authorized, trained, and unlicensed HCA employee. I authorize the listed health care provider to disclose health information to the school and for the school to disclose the above information to those within the school that have a need to know for legitimate educational purposes. I hereby release the school liability due to allergic reaction(s).

Parent/Guardian Signature: _____ Date: _____

Cell Phone: ____ - ____ - _____ Work Phone: ____ - ____ - _____

Preferred Email (for school clinic medication reminders): _____

Faculty Review for Controlled Medications:

Medication was received from: _____ Date: _____

Medication was received by: _____ Date: _____

Initial Count (pills or tablets):

_____

Witness Signature _____ Date: _____