Highland I.S.D.

6625 FM 608
ROSCOE, TEXAS 79545
(325) 766-3652

Parents,

Your child may have an illness that requires medication for relief or cure that does not prevent his or her attending school. When possible, such medication should be scheduled to be taken at home. However, according to Texas State Legislature, and ISD Board of Trustee policy, a medication may be dispensed to a student by school personnel. The following requirements must be met by the parent or legal guardian requesting this service.

1. **Prescription or non-prescription drugs** that need to be taken at school for 15 days or less.
   a. All prescription drugs must be in their original pharmacy container and labeled by the pharmacist. The label must include:
      1. Student's name
      2. Name of prescribing health care provider
      3. Name of drug
      4. Amount of drug to be given and frequency of administration
      5. Date prescription filled

   b. All non-prescription drugs must be in their **original container**. The written request for administration of these must contain the following information:
      1. Student's name
      2. Name of drug
      3. Amount of drug to be given
      4. When drug is to be given
      5. Reason drug is given
      6. Date
      7. Signature of parent or guardian

   c. All prescription and non-prescription drugs to be administered at school for 15 days or less must be accompanied by a **written request, signed and dated by a parent or legal guardian.** (Form attached)

2. **Prescription or non-prescription drugs** that need to be taken at school for **more than 15 days.**
   a. All prescription and non-prescription drugs to be administered at school for longer than 15 days must be accompanied by a **written request signed and dated by the prescribing health care provider and the parent or guardian requesting this service.** (Form attached)

To comply with Texas State Law, the following restrictions apply to the taking of medicine by students while at school:

1. All medicine is to be brought to and kept in the school nurse's office.
2. Prescription and non-prescription medicine must be in the original container. Prescription medicine must be in a container with the pharmacy label for that student.
3. If a prescription or non-prescription medicine must be given during the school day, it must be accompanied by a note signed by a parent or guardian giving authorized school personnel directions for its administration (time and dosage).
4. School personnel will not give any medicine, including Tylenol, unless it is provided by you, in the appropriate manner as stated above.

These restrictions are necessary for protection of the health and safety of your child. We will appreciate your cooperation in this matter.

Sincerely yours,

Morgan E. Martin, RN
School Nurse

(325) 766-3652
Phone number

****Please keep the attached form available for future use should your child need to take a medication during school hours****

Authorization/Parental Consent for Administering Medication
(Use a separate authorization form for each medication)

Student's Last Name _____, First Name_____, M.I. ____
Student Number _____ Grade _____ Date of Birth _____
Allergies _____

Parental Consent

I am the parent or guardian of _____. I give my permission for him/her to take the following prescribed medication while in Highland School. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medications. I hereby release Highland School and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the above licensed prescriber.

_____ _____ _____
Parent/Guardian Signature Daytime Phone Date

MEDICATION AUTHORIZATION
(For Use By Licensed Prescriber ONLY)

Relevant Diagnosis_____ Medication_____

Dates medication must be administered at school:
_____ Short Term (List dates to be given _____)
_____ Every day at school
_____ Episodic/Emergency ONLY

Dosage (Amount) _____ Route _____ From _____ Time(s) of Day _____

A. Serious reactions can occur if the medication is not given as prescribed:
_____ YES _____ NO
If yes, describe:

B. Serious reactions/adverse side effects from the medication may occur:
_____ YES _____ NO
If yes, describe:

Action/Treatment for reactions: _____
Report to you: _____ YES _____ NO (Drug information sheet may be attached)
Special Handling Instructions _____ Refrigeration _____ Keep out of sunlight
Other: _____

ASTHMATIC/DIABETIC ONLY
This student is both capable and responsible for self-administering this medication:
_____ NO _____ YES-Supervised _____ YES-Unsupervised
This student may carry this medication: _____ NO _____ YES
Licensed Prescriber's Name: _____
Phone Number: _____ Emergency Number: _____
Licensed Prescriber's Signature: _____ Date: _____

Parental Permit to Administer Prescription or Non-prescription Medication at School for 15 Days or Less

Student Name: Last	First MI Age
Grade: Teacher:	
Prescription Medication	Non-prescription Medication
Name of drug	Name of drug
Time to be given	Time to be given
Amount to be given	Amount to be given
Reason medication being given	
Number of Tablets Pills Capsules Other	
Send only the amount a student needs to take at school in properly labeled, original containers, so that students will not be required to carry medication back and forth from home to school.	
Parent/Guardian signature	Date
Home telephone	Work telephone

- -

Physicians—Parent Permit to Administer Prescription or Non-prescription Medication at School for more than 15 Days

Student Name: Last	First MI Age
Grade: Teacher:	
Reason student receiving medication	
Name of medication	Dosage Date to DC
Possible reactions	
Form of medication Tablet Pill Capsule Liquid Inhalant Other	
Feedback requested Yes No How Often	
Physician's Signature	Date How Often
This is the school's permission to give (student name) the above medication as prescribed by Dr. (physician name) as he directs.	
Parent/Guardian signature	Date
Home telephone	Work telephone