Belton ISD Health Services
Parental/Physician Authorization for Administration of Medication
School Year: 2019-2020 Campus:

Student Last Name	Student First Name	DOB/ BISD ID#	Grade/HR#

Medication	Dose/Route/Time (s)

Specific instructions/ Precautions/side effects on your child:

Pharmacy /#	Expiration Date	Condition for which medication is required:

Parent answers all questions below:

Yes ○ **No** ● **Student in Special Education Program?** **Yes** ○ **No** ● **Student in 504 program? (School accommodations for those with chronic health issues)**

Yes ○ **No** ● **Is this the initial dose of a new medication that has not been previously given to your child?**

Yes ● **No** ○ **NA** **If noon med: My Child is to receive medication prior to release on early dismissal days**

Yes ○ **No** ○ **Will your child need this medication during field trips? If yes, please ask your pharmacy to provide the school with a properly labeled empty container.**

My signature below indicates that I request and grant permission to the BELTON ISD to administer medication to my child. I am giving permission to BISD staff to contact my physician for additional information if necessary. If the school nurse deems it necessary, I grant permission to notify my child's teacher(s) of possible reactions that might occur while taking this medication. I understand that unlicensed school personnel assigned by the principal may give the medication. I understand that a new parent and physician authorization is required for any change in the dosage or time of this medication. I understand my child cannot carry this medication unless permitted by law, and that a parent/guardian should bring and pick up any medication given at school. I understand all medication will be disposed of on the last day of school unless picked up by parents.

Parent Signature	Date	Daytime Phone	Cell

Additional Physician Instructions:

Physician: Print Name	Physician Signature	Date	Phone

For BISD Staff Use Only

Date	#Pills/ml	Counter Signature	Witness Signature	Date	#Pills/ml	Counter Signature	Witness Signature

Notes:

Trained Staff- Print name and initial after completing training on administering this medication, which includes seeking additional training or assistance as needed when administering this medication. **Document administration of medication below if trained staff unable to document in the student's electronic health record (Skyward) at the time of administration.**
Trainer- sign and date beside name of staff member that has completed the knowledge and skills to administer this medication.

Trained staff: Print Name/initial	Trainer Signature	Training Date	Trained staff: Print Name/initial	Trainer Signature	Training Date

If administered, place date, time, and initials in the boxes below.

Date																	
Time																	
Initials																	