Belton ISD Health Services

Update-May2023

Parental/Physician Authorization for Administration of Medication

School Year: **Campus**: **Student ID: _____**

Student Last Name	Student First Name	DOB	Grade/Homeroom	Transportation: ☐ Rides bus #_____ ☐ Car rider ☐ Walker

Medication (include strength/concentration)	Dose/Route/Time (s)

Specific instructions/ Precautions/side effects on your child:

Pharmacy / # (or OTC/Brand if non-prescription)	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

Medication Inventory: (Please also document each new inventory within the specific Skyward medication entry under 'Notes')

Date	#Pills/ml	Counter Signature	Witness Signature	Pharmacy (or OTC)	Prescription #	Expiration Date

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																	

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ADDITIONAL MEDICATION INVENTORY: (Please also document each new inventory within the specific Skyward medication entry under 'Notes')

Date	**#Pills/ml**	**Counter Signature**	**Witness Signature**	**Pharmacy (or OTC)**	**Prescription #**	**Expiration Date**