

**LEWISVILLE ISD HEALTH SERVICES
MEDICATION ORDERS, PARENT AUTHORIZATION AND CONSENT**

Name: _____ DOB: ___/___/___ School: _____ Teacher/Grade: _____

School Phone: _____ Fax: _____ School Nurse: _____

Condition for which medication is to be given at school and administration instructions:

List all medications or therapies to be given at school for this condition. Use an additional form for other conditions.

Medication	Route	Dose	Times of Indications for Use
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Physician/Dentist Signature _____ Print Name _____

Office Number: _____ Fax Number: _____

Valid for one school year. Physician/Dentist must be licensed to practice in Texas. Temporary (two months) orders from out-of-state US Physicians are acceptable to initiate treatment for transferring students. A signature is required for controlled substances, daily, or PRN therapy lasting over 15 days or changes in the original prescription order. A 15 day grace period is allowed for required physician or dentist orders and signatures.

I request and authorize the Lewisville ISD to administer the above medication as prescribed. I understand that the school administrator may designate any qualified person or persons to administer this medication. I also understand that although a reasonable attempt will be made to remind the student, it is expected that the student will be responsible in most situations for remembering to visit the health room for his medicine. Medication doses that could reasonably be taken at home will not usually be administered at school.

Non-prescribed, over-the-counter medications may be given for **one school week** and cannot be renewed without a prescription. A written parent request and full information is mandatory for each medication.

I also authorize the school's registered nurse and the prescribing physician (printed name of physician) _____ to discuss this medication order, to clarify this medication order, or in the interest of this student's health (printed name of student), _____, to discuss his/her response to the prescribed medication as required by Nurse Practice Act and Medical Practice Acts of Texas. It is expected that the school nurse will first attempt to notify a parent/guardian should such a contact become necessary. **If the consent for the nurse and the doctor to consult re: this medication order is not granted or is revoked, it may not be possible for school personnel to administer the prescribed medications.**

For student safety, all medications should be transported to and from school by an adult. It is recommended that students should not carry medications to and from school. The school cannot assure medication(s) or equipment will arrive safely and intact.

_____ I **GIVE** permission for the school to allow my child to transport medication and equipment

_____ I **DO NOT GIVE** permission for the school to allow my child to transport medication and equipment to and from school. The medication will always be picked up or delivered by a designated adult.

PARENT/LEGAL GUARDIAN SIGNATURE _____