Cleburne ISD Health Services

Medication Administration Authorization Form

Student: ________________________ DOB: ____________ School Year: _________________

CISD Campus: ___________________ Grade: ___________ Teacher: ___________________

***One medication order per medication form (Prescription and Over the Counter) written below by the Physician/PA/NP.**

Medication Name	Medication Dose/ Medication Route	Time to be given (ie: lunch)	Medication Duration

**** Only FDA approved medications can be administered at school.***

Physician/PA/NP Signature: _____________________________Date:_________NPI#_________

Physician/PA/NP Name: _______________________Office Phone: ______________________

** In accordance with the Nurse Practice Act, Texas Code Section 217.11 the school nurse has the responsibility and authority to clarify any medication order with appropriate licensed practitioner and/or refuse to administer medication that in the nurse's judgment is not in the best interest of the student.

Print Name of Staff receiving Medication with this form	Date Received	Medication Expiration	CISD Staff Signature

Campus RN reviewed the above medication on ____________ RN Signature ______________________

I give permission, as the parent/guardian of the above student, for my student to receive the medication as ordered above by a physician/PA/NP at school according to the Medication Administration Protocol and board policy.

By signing this form, I agree with the CISD Medication Protocol/Policy and release Cleburne ISD from any liability.

Parent/Guardian Signature: ____________________________________ Date: ________________________

Printed Parent/Guardian Name: _________________________________ Date: _________________________

Primary Contact Phone for Parent/Guardian: ____

STUDENT NAME:______________________________ MEDICATION:______________________

Date Reviewed												
DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY
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DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY

Signature:____________________ Signature:____________________ Signature:______________________

Charting Codes: A= Absent, DC= Discontinued, FT= Field Trip, OOM= Out of Medication, SF= Sent For

Date	#pills	office signature	parent signature	EXP	Date	#pills	office signature	parent signature	EXP

Updated 4/22/2021
Updated 4/22/2021

Updated 9/8/21