

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

Physician/PA/NP Signature: _____ **Date:** _____

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.

____ (parent/guardian initial) * I have received a copy of the Medication Administration Protocol for CISD and by initialing, agree with CISD medication protocol/policies.

By signing this form, I release Cleburne ISD from any liability.

Parent/Guardian Signature: _____ Date: _____

Printed Parent/Guardian Name: _____ Date: _____

Primary Contact Phone for Parent/Guardian: _____

