Campbell ISD
409 W. North Street
Campbell, TX 75422
903-862-3250
903-862-3547 fax

Physician/Parent Authorization and Request for Medication Administration at School

Requests for administration of medication by school personnel must be as follows:

1. When such medication(s) cannot be given outside of the school day.
2. Prescription medications require both physician and parent request to continue to be taken at school when the medication needs to be taken beyond a 10-day period of time. (FFAC – LOCAL).
3. Over-the-Counter medications may be given if provided by the parent along with a parental permission note and signature requesting administration of the medication provided.
4. All Medication must be in the original container properly labeled by the pharmacist filling the prescription, or labeled by the manufacturing Drug Company if the medication is available over-the-counter. (Texas Education Code 21.914).

Student's Name: _____ Date of Birth: _____

Student Grade: _____ School Year: _____

Condition for which medication(s) is required: _____

1. Medication: _____

   Dosage _____ Time _____

Additional Instructions, Side effects, Precautions: _____

Physician's Signature: _____ Date: _____

Physician Printed name: _____

Parents/Guardians: Please complete this part of the form or provide separate Parent/Guardian authorization note. Thank You.

I, the parent/guardian of _____ request the above medication be administered to the above named student.

The Nurse may find it necessary to contact your child's health care provider for information/clarification of a medication order or the condition requiring medication. Your signature below will give the nurse permission to request information.

I do hereby give my consent for the release and exchange of information contained in the medical or professional record of my child (named above).

Parent/Guardian Signature: _____ Date: _____