Mumford ISD
Medication Permission Form

A parent/guardian must give a written request to administer medications at school. The medication must be in the original container and properly labeled with student's first and last name and dosage given. A separate form must be filled out for each medication.

Persons who may assist your child with medications include the school nurse (RN) and campus staff. School personnel are not responsible for any adverse effects which might occur from this medication.

NOTE: THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION MAY NOT BE GIVEN AT SCHOOL.

OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN TWO WEEKS MUST HAVE REVIEW AND APPROVAL OF THE SCHOOL NURSE AND MAY REQUIRE A PHYSICIAN'S ORDER.

NAME OF STUDENT: _____ DOB: _____

DRUG / FOOD ALLERGIES:_____

NAME OF MEDICATION:_____

EXACT DOSAGE: _____ ROUTE: _____
(Example: 400mg, 1 tsp, 2 puffs, 3 drops) (Example: by mouth, inhaler, with food or after meals, empty stomach, eye drop

TIME TO BE GIVEN AT SCHOOL: _____ REASON FOR MEDICATION: _____
(Example: As needed, after breakfast) (Example: ADHD, Asthma, headache)

MEDICATION TO BE GIVEN FROM: _____ TO: _____ ☐ End of School
mm-dd-yy mm-dd-yy

ADDITIONAL INSTRUCTIONS/RESTRICTIONS: _____

HAS THIS MEDICATION BEEN ADMINISTERED AT HOME: ☐ Yes ☐ No

TEACHER: _____ GRADE: _____

PHYSICIAN NAME:_____PHYSICIAN PHONE:_____

By signing this form, I authorize the school personnel to administer the medication listed above, to the indicated student, during school hours. I authorize the school's registered nurse to contact the prescribing physician for clarifications needed regarding the medication listed below to assure safe administration. I understand if the circumstances are questionable, the school employee reserves the right to deny my request while clarification is being sought. I release MISD and its employees from any claims or liability connected with its reliance on this permission I have completed and reviewed this form and all the information is accurate.

_____ _____
PARENT'S/GUARDIAN SIGNATURE DAYTIME PHONE

_____ _____
PARENT'S/GUARDIAN NAME (printed) DATE

RN Signature of Review: _____ Date of Review:_____