Medication Permission Form

Dripping Springs High School

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When it is necessary for a student to receive medication during the school day (please see DSISD Student Handbook for guidelines), the following procedures **must** be followed:

- Parents/guardians must provide all medication and parent/guardian signature is required for all medications given at school.
- A US-licensed physician's signature is required for:
  - All controlled substances (ex. narcotic pain meds & most ADHD medications)
  - Over the counter medications to be administered a maximum of 10 school days or two weeks
  - Medications prescribed differently from manufacturer's directions.
- All medication must be in the original container & clearly labeled with the student's name, medication, dosage & directions for administration. All controlled substances must be hand-delivered to the school nurse by the parent/guardian or their representative age 18+.
- The Medication Administration Request Form must be completed each school year *and* when there are any changes to the original request including, but not limited to, medication and/or dose change. A separate form must be completed for each medication. Parents are responsible for keeping up with the amount of medicine given to the nurse and knowing when their student is running low at school.
- Only FDA approved pharmaceuticals will be administered. No homeopathic preparations, herbals, home remedies, or dietary supplements will be accepted nor administered by any school personnel. Herbal or dietary supplements provided by the parent only if required by the student's individualized education program (IEP) or 504 plan.

Parents/guardians are strongly encouraged to pick up all medication after it is discontinued. All unclaimed medication will be destroyed at the end of the school year.

I, _____, request and give permission for school personnel at Dripping Springs High School to give my child, _____, the following medication according to the stated directions. I understand and agree that the school will not be held responsible for any ill effects which might occur in connection with the administration of this medication.

Medication:	Dosage:	Diagnosis/Reason:
Drug allergies:	To be given from: _____ to:_____	
Parent/guardian signature:		Date:

Physician Orders For Medication

Medication:	Dosage:	Route:
School administration time:		Diagnosis:
Start (please check): _____ Date form received _____ Other, as specified: _____		End: _____ End of school year _____ Other, as specified:_____
Physician signature:		**Date:**
Physician Name (please print):		Phone: