FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Medication Administration Information

Texas law permits a public school to administer medication prescribed by a physician/licensed prescriber to a child on behalf of the parent or legal guardian under certain limited circumstances with an appropriate written authorization. The only medication that may be given at school is that which is necessary to enable the student to remain in school. If possible, all medication should be given outside of school hours. Three times a day medication can be given before school, after school and at bedtime. All medications and equipment shall be provided by the parent or legal guardian. If necessary, medication can be given at school under the following conditions:

1. Medications must be in original, properly labeled containers. The pharmacy can supply two (2) labeled bottles for this purpose. Medications sent in baggies or unlabeled containers will not be given.

2. Medications will not be given without a specific written request signed by at least one parent or legal guardian and physician/licensed prescriber. This request shall be made on the appropriate form supplied by the school or on a form supplied by your physician/licensed prescriber.

3. Medications may be given by a staff member designated by the principal and trained by the school nurse.

4. Medications must be kept in the nurse's office in a locked cabinet.

5. Parents may bring up to one month's supply of medication. Empty medication containers may be given to students.

6. Herbal medications, dietary supplements and other nutritional aids not approved as medication by the FDA may not be administered at school.

Please contact your school nurse if there is question.

School Nurse: MS Skinner RN

School: Overton Park Elementary

Phone Number: 817 814 6920

melani.skinner@fwisd.org

FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Medication Administration Request Form

Student: _____ Date of Birth: _____

School Name: _____ Grade: _____

Physician/Licensed Prescriber to complete: Medication

Allergies: _____

MEDICATION(S)	STRENGTH	DOSAGE	ROUTE	TIME(S)	COMMENTS

Physician/Licensed Prescriber's Signature: _____ Date: _____

Physician/Licensed Prescriber's Printed Name: _____

Phone: _____ Fax: _____

Parent/Guardian to complete:
I hereby represent and attest that I am the parent or legal guardian of the above-named student. I hereby request that the medication(s) specified above be administered to the above named student beginning on the following date: _____ and ending on the following date: _____
As long as a physician authorizes a refill of any prescription set forth above, this authorization shall apply to any such refills. On behalf of the above named student, myself, and our personal representatives, family members, heirs, assigns, and successors. I also agree and do hereby waive and release all claims for loss, damage, or injury against the Fort Worth Independent School District and any teacher, employee, volunteer, agent, or other person arising directly or indirectly out of any act or omission relating to the receipt, administration, or execution of this request. I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

Parent/Legal Guardian's Signature: _____ Date: _____

Parent/Legal Guardian's Printed Name: _____

Telephone: Home _____ Cell _____ Work _____

CONFIDENTIAL PROTECTED HEALTH INFORMATION: This document contains or requests "protected health information" within the meaning of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Federal and Texas law and District policy prohibit, and require utilization of appropriate safeguards against, wrongful use, access or disclosure of protected health information, other than as allowed by applicable Federal and state law and District Policy. Wrongful access, use, or disclosure of this information may expose violators to civil and criminal liability under Federal and/or State law, discipline by the District, or both.

FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Self- Administration of Prescribed Asthma or Anaphylaxis Medicine by Student

This form is to be completed by the parent and physician/licensed health care provider of students who are to keep prescribed asthma or anaphylaxis medication on their person and self- administer it as prescribed.

School Name: _____ *School Year:* _____

Parent Request

We, the undersigned parents of _____ *request that our child be allowed to keep the prescribed asthma or anaphylaxis medication on his/her person at all times and self- administer it as requested by the physician.*

We understand that it is the student's sole responsibility to keep the prescription medication on his/her person. If they are misplaced or used by other students, this privilege will be revoked.

I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

_____ _____
Signature of Parent(s) *Date*

Physician Request

You are hereby authorized to allow _____ *to carry the prescription medicine on his/her person at all times.*

_____ _____
Name of Medication *Dosage and Time of Administration*

Please check all that is applicable.
_____ *Student is knowledgeable about the medication and how to administer it.*
_____ *Student has the skills to safely possess and use the prescribed medication.*
_____ *Student may self-administer the medication.*

All authorizations expire at the end of the school year.

_____ _____
Signature of Physician/Licensed Health Care Provider *Telephone Number*

_____ _____
Printed Name of Physician/Licensed Health Care Provider *Date*

The student has demonstrated the skill level necessary to self-administer the prescription medication including the use of any device required to administer the medication.

_____ _____
Signature of School Nurse *Date*

R6/13/07