Houston Independent School District
Health and Medical Services

Policies Governing Administering Medication During School Hours

The policy of the Board of Education does not authorize Houston school personnel to give medication of any kind. That includes aspirin, similar preparation, or any other drugs.

Nurses and other school personnel, however, can give medication during school hours under the following restrictions. Pupils who are noncontagious, on long-term medication, on preventative medication, or for a prolonged period on medication that cannot under any arrangement be administered other than during school hours may take medication in school. The healthcare provider's statement must be accompanied by written permission of at least one parent.

Healthcare Provider's Request for Administration of Medication at School Building During School Hours

To the principal of: _____ School Date: _____

Name of child: _____ Birthdate: _____

Diagnosis: _____ ❑Infections ❑ Non-Infectious

In order to keep this child in optimal health and to help maintain school performance, it is necessary that medication be given during school hours.

Name of medication: _____ Color (if applicable): _____

Form of medication:

❑tablet ❑ pill ❑ capsule ❑liquid ❑ inhalation ❑ injection*

❑other (specify):_____

(* Injectable medications may be given at school only when the family physician addresses a written request for this service to Director of Health and Medical Services, giving detailed information concerning the administration of the medication and follow-up. Parents shall be instructed to furnish sterile, disposable syringes and needles which will be returned to the parent for disposal after use.)

Dosage (amount to be given): _____

Frequency: _____

Common side effects: _____

Remarks:_____

This is permission to give medication to my child named above as requested by the physician. I understand that I am giving consent for the school nurse to discuss any concerns regarding this medication with the healthcare provider whose signature appears on this document in order to monitor the healthcare needs of my child.

_____
Parent's Signature

_____
Telephone:

_____
Date:

_____
Facility Name

_____
Physician's/Advanced Practice Nurse Signature

_____
Physician's/Advanced Practice Nurse Name (print or type)

_____
Telephone