Houston Independent School District
Health and Medical Services

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

This form must be filled out completely to allow the School Nurse and /or other trained staff assigned by the Principal to administer medication to a student. A new medication form must be completed at the beginning of each school year for each prescription medication, and each time there is a change in the medication's administration instructions.

In accordance with district policy, only prescription medication will be administered.

- Prescription medication must be delivered to school in its original container.
- The container must be properly labeled by a pharmacist.

Student's Name _____ Sex _____

Date of Birth ____/____/____ Name of School _____

Medical Diagnosis: _____ ☐Infectious ☐Non-Infectious ☐Allergy

Medication Name: _____

Dose (amount to be given): _____

Frequency (how often): _____

Form of Medication (Route): _____

☐tablet ☐pill ☐capsule ☐liquid ☐inhalation ☐injection

☐ other (specify): _____

Possible side effects _____

Special requirements for administration / storage _____

Known food allergies YES NO If Yes, please explain _____

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 to monitor the healthcare needs of my child.

_____
Parent's Signature

_____
Telephone

_____
Date

_____
Physician's/Advanced Practice Nurse Signature

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

_____
Date

_____
Facility Name

_____
Telephone

Houston Independent School District
Health and Medical Services

Policies Governing Self -Administration of Emergency Medication for Treatment of Asthma, Anaphylaxis and Diabetes while on School Property or a School Related Activity

District policy allows a student at risk for anaphylaxis or a diagnosis of asthma, or diabetes to possess and self-administer prescription medicine for management of their care under certain conditions.
This form must be filled out completely to allow students with these conditions to possess and self-administer prescription medicine. A new medication form must be completed at the beginning of each school year for each prescription medication, and each time there is a change in the medication's administration instructions.
It is important to note the following:

- By signing below, the health care provider and parent confirms that the student is capable of self-administration of the medication.
- The School Nurse may re-evaluate the student's ability to self-administer medications as needed
- Self-administration orders must be included in the Diabetes Medical Management Plan (DMMP) for students with diabetes.
- This serves as an exception to the HISD medication policy that requires all medications to be kept in a locked area in the nurse's office.

Student's Name _____ Sex_____

Date of Birth ____ / ____ / ____ Name of School _____

Medical Diagnosis: _____ ☐Infectious ☐Non-Infectious ☐Allergy

Medication Name: _____

Dose (amount to be given): _____

Frequency (how often): _____

Form of Medication (Route): _____

☐tablet ☐pill ☐capsule ☐liquid ☐inhalation ☐injection

☐ other (specify): _____

Possible side effects _____

Student has demonstrated that they can self-administer their medication Yes No

If NO, please explain other support needed to achieve independence _____

This is permission for my child named above to self-carry medication 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 to monitor the healthcare needs of my child.

_____
Parent's Signature

_____
Telephone:

_____
Date:

_____
Physician's/Advanced Practice Nurse Signature

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

_____
Date

_____
Facility Name

_____
Telephone