Salado ISD Health Services Year:_____

Parental/Physician Authorization for Administration of Medication (Physician must fill out for prescriptive medication!)

Campus: 2015-2016

Student	DOB	Grade/HR#	SISD ID#
Medication	Dose/Route	Time(s)	Pharmacy
Is this the initial dose of a new medication that has not been previously given to your child? ☐Yes☐No	Expiration Date	Condition for which medication is required:	Dates to be administered:
Specific instructions/ Precautions/side effects on your child:			

My signature below indicates that I request and grant permission to the SALADO ISD to administer medication to my child. I am giving permission to SISD staff to contact my physician for additional information if necessary. If the school nurse deems it necessary, I grant permission to notify my child's teacher(s) of possible reactions that might occur while taking this medication. I understand that the medication may be given by a medically untrained designee of the principal.

☐My child NEEDS this medication during field trips. I will provide the school with an empty container labeled by the pharmacy to be used for field trips.

All medication will be disposed of on the last day of school unless indicated below: ☐I will pick up the medication or ☐I want the school to dispose of the medication

☐ My secondary child has my permission to carry the medication home, with the exclusion of any controlled medication. I understand that parents shall be solely responsible for the actions of their child and the medication once it leaves the clinic. Parents and students should be familiar with policies which have been adopted by the school board pertaining to the possession and use of drugs.

Parent Signature	**Date**	**Daytime Phone**	**Cell**

Physician Authorization (Prescription Medication)

Additional Physician Instructions:

Physician: Print Name	**Physician Signature**	**Date**	**Phone**

For SISD Staff Use Only

Date	#Pills/ml	Counter Signature	Witness Signature	Date	#Pills/ml	Counter Signature	Witness Signature

Notes: