Texas City Independent School District

1700 Ninth Avenue North, P.O. Box 1150, Texas City, Texas 77592-1150

Authorization for Administration of Prescribed Inhaled Medication

Name of Student: _____ Birthdate: _____

School: _____ School Year: _____ Grade: _____

Medical Condition	Medication Strength	Dose	Time	Route	Side Effects Possible
1.					
2.					
3.					

Other Considerations/Directions: _____

Start Date: _____ Stop Date: _____

(All authorizations expire at the end of the school year.)

☐ Student is knowledgeable about the medication and how to administer it.

☐ Student has the skills to safely possess and use an inhaler.

☐ Student may self-administer the medication. (Not applicable for controlled substances.)

_____ _____

Print or Type Name of Physician/Licensed Prescriber Signature

_____ _____ _____

Clinic Address Phone Number Date

Parent/Guardian Authorization - Please initial the following:

_____ I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.

_____ I release school personnel from liability in the event adverse reactions result from taking the medication(s).

_____ I will notify the school of any change in the medication(s), (e.g. medication change, dosage change, medication is discontinued, etc.)

_____ I give permission for the school nurse to communicate with my child's teachers about the student's health condition(s) and the action of the medication(s).

_____ I give permission for the school nurse to consult with my child'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).

_____ I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

_____ My son/daughter may self-administer his/her inhaled medication(s). (Not applicable for controlled substances, such as Ritalin, Dexedrine, Codeine, etc.)

_____	_____	_____
Date	Parent/Guardian Signature	Relationship to Student

Note: Medication must be supplied in the original prescription bottle and the container (<u>not the box</u>) must be properly labeled with the prescription/pharmacy label with the student's name, type of medication, dosage, route and time noted.