See the following forms regarding administering medication and emergency health care to students:

Exhibit A: Request for the Administration of Medication at School — 2 pages

Exhibit B: Authorization to Secure Emergency Medical Treatment of a Student — 2 pages

Exhibit C: Authorization for Self-Administration of Asthma and Anaphylaxis Medication — 1 page

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Note: Sample medication logs can be found in Chapter 5 of the Texas Department of State Health Services *Texas Guide to School Health Programs* at http://www.dshs.state.tx.us/schoolhealth/shpguide/chap5.pdf.

EXHIBIT A

REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

Date form was received by the school: _____

Student name: _____

Date of birth or age: _____

Grade: _____ Teacher/Classroom: _____

Name of medication: _____

Reason for medication: _____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer

☐ Other: _____

Instructions: (Schedule and dose to be given at school): _____

_____

Start: ☐ Date form received ☐ Other date: _____

Stop: ☐ End of school year ☐ Other date: _____

Restrictions and/or important side effects:

☐ None Anticipated

☐ Yes. Please describe: _____

_____

Special storage instructions:

☐ None ☐ Refrigerate ☐ Other: _____

Physician Information:

Name: _____

Address: _____

Phone Number: _____

Physician Signature: _____ Date: _____

To be completed by parent/guardian:

I give permission for _____ *(name of child)* to receive the above medication at school in accordance with District policy [See FFAC]

Parent/Guardian Signature: _____ Date: _____

[Developed using resources from the American Academy of Pediatrics and Texas Department of State Health Services]

EXHIBIT B

AUTHORIZATION TO SECURE EMERGENCY MEDICAL TREATMENT OF A STUDENT

Student name: _____ Grade: _____

Date of birth: _____/_____/_____

Parent name(s): _____

Work phone: _____ Home phone: _____

Work phone: _____ Home phone: _____

Mobile phone: _____ Mobile phone: _____

Address: _____

Local person to contact if parent cannot be reached:

Name: _____

Phone: _____

Relationship to student: _____

Student's physician or other preferred health-care provider:

Name: _____

Phone: _____

Student's dentist:

Name: _____

Phone: _____

Medications or drugs to which the student has had an allergic or adverse reaction:

_____

_____

_____

Part 1:

I hereby authorize the Superintendent of _____ School District or a designated representative to secure any and all emergency medical care and treatment for _____ *(student's name)* for acute illness suffered, injury sustained, or other situation requiring emergency medical treatment while at school or participating in school-related activities. I prefer that emergency treatment be secured at _____

_____ *(indicate preferred medical facility)*; the District may use another licensed hospital, clinic, or medical facility, if necessary, with the following exceptions: _____.

I understand that cost of services provided by ambulance, private physician, clinic, hospital, or dentist remains the responsibility of the parent or guardian and will not be assumed by the District or any of its officers or employees.

I ☐ do not have ☐ do have medical insurance coverage on my child with _____.

Parent's signature: _____Date: _____

Part 2: *(Include this section only if the District's policy permits.)*

This is to certify that I authorize the Superintendent of _____ School District or a designated representative to provide and administer to _____ *(student's name)*:

☐ Tylenol (or generic acetaminophen) if my child has a temperature of 101 or higher;

☐ Benadryl (or generic antihistamine) if my child experiences a local or systemic allergic reaction such as hives, welts, severe swelling, generalized itching, or tingling of the mouth or throat; or

☐ _____ *[other medications specific to another emergency situation as determined by the District's medical advisor]*

I understand that the District will attempt to contact me as soon as possible if such action is necessary.

Parent's signature: _____ Date: _____

Copies of this authorization may be presented to the admissions office of a hospital or clinic or to a physician or dentist. Other distribution will occur only within the limitations of the Family Educational Rights and Privacy Act.

EXHIBIT C

AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA AND/OR ANAPHYLAXIS MEDICATION

Note: For information addressing students at risk for anaphylaxis, see FFAF.

Student name: _____ Grade: _____

Parent name(s): _____

Work phone: _____ Home phone: _____

Work phone: _____ Home phone: _____

Address: _____

Prescribing physician or health-care provider:

Name: _____

Phone: _____

Description of condition/reason for medication: _____

_____

Prescribed medication and dosage: _____

How/when the medication should be used at school *(dosage, method, times)*: _____

_____

Anticipated length of treatment: _____

Possible adverse reaction: _____

_____ *(student's name)* has asthma and/or anaphylaxis and is treated with prescription medication. *(He)(She)* is capable of administering *(his)(her)* own medication at school and at school-related or school-sponsored activities. The District will be informed of any changes to the medication specified on this form, to the dosage, or to the recommended regimen by an updated version of this consent form.

_____ _____
Parent Signature Date

_____ _____
Health-care Provider Signature Date