SCHERTZ-CIBOLO-UNIVERSAL CITY INDEPENDENT SCHOOL DISTRICT
Medication Authorization Form

STUDENT: _____ **DOB:** _____

SCHOOL/CAMPUS: _____ **GRADE:** _____

REASON FOR MEDICATION: _____

- MEDICATION (INCLUDING REFILLS) **MUST** BE DROPPED OFF BY A PARENT / GUARDIAN / ADULT DESIGNEE
- MEDICATION **MUST** BE DROPPED OFF IN ORIGINAL BOTTLE WITH PHARMACY PRESCRIPTION LABEL (WHEN APPLICABLE) ***ASK PHARMACY FOR AN EXTRA LABELED BOTTLE FOR MEDICATION GIVEN AT HOME & AT SCHOOL***
- **PHARMACY LABEL MUST INCLUDE**: STUDENT NAME, NAME OF MEDICATION, DOSE TO BE GIVEN, TIME OF ADMINISTRATION, ANY OTHER SPECIAL INSTRUCTIONS
- PHARMACY LABEL **MUST** MATCH PHYSICIAN ORDER / INSTRUCTIONS
- VITAMINS / HERBAL SUPPLEMENTS / ESSENTIAL OILS **WILL NOT** BE ADMINISTERED AT SCHOOL
- DISCONTINUED / LEFTOVER MEDICATION **MUST** BE PICKED UP BY A PARENT / GUARDIAN / ADULT DESIGNEE

SPECIAL INSTRUCTIONS FOR ADMINISTRATION: _____

MEDICATION	DOSE	TIME	ROUTE

I give permission for SCUCISD school personnel to give the listed medication to the above named student during school hours. I understand per Section 22.052 (2) of the Texas Education Code that the school district, its board of trustees and its employees are not liable for damage or injuries resulting from the administration of this medication. In addition, the licensed school nurse has the responsibility and authority to refuse to administer medications that, in the nurse's judgment, are not in the best interest of the student. (Board of Nurse Examiners Rule, 22 Texas Administration Code 217.11).

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____ _____

PRINTED NAME **CONTACT PHONE NUMBER**

PHYSICIAN ANNUAL PRESCRIPTION AUTHORIZATION

(ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS GIVEN LONGER THAN 10 SCHOOL DAYS MUST HAVE A PHYSICIAN/PA/NP SIGNATURE)

_____ _____

AUTHORIZED SIGNATURE **DATE**

_____ _____

PRINTED NAME **OFFICE PHONE NUMBER**

****ORDER VALID FOR CURRENNT SCHOOL YEAR AND MUST BE RENEWED ANNUALLY****