RAINS ISD

PERMISSION TO ADMINISTER MEDICATION

Medications should be given at home whenever possible. However, when dosage instructions require medication to be administered during the school day, the following policy requirements must be met.

In compliance with Texas Department of Health guidelines, Rains ISD does not provide any medications for students. If you, as this student's guardian, would like to provide over-the-counter (OTC) *or* prescription medication for use during school hours, all medications **must be in their original, unopened (OTC only), and properly labeled container.**
All medications will be administered by either the nurse or designee.
Over-the-counter medications given for 5 consecutive days or at the discretion of the nurse will require a physician's order.

Student Name:_____Age:_____Grade:_____Teacher:_____
Does this student have any medication, food, or latex allergies? Yes No
If so, please list allergen and response to allergen: (example: Penicillin/Hives)
1)_____/_____ 2)_____/_____
3)_____/_____ 4) _____/_____
Has an epi-pen?: Yes No

Please give the following medication to my child as directed below:

Prescription	OTC	Name & Dosage Of Medication	Amount to be given	When/How often to be given	Reason for medication
1. ❑	❑	_____	_____	_____	_____
2. ❑	❑	_____	_____	_____	_____
3. ❑	❑	_____	_____	_____	_____
4. ❑	❑	_____	_____	_____	_____
5. ❑	❑	_____	_____	_____	_____

Please indicate how you want medications to be dispersed at the end of this school year:

❑ Parent/Guardian will pick up medications from campus clinic on or before the last day of school.
❑ Please destroy any medication remaining.
Any medication remaining after the last day of school will be destroyed.

Parent/Guardian Signature:_____Relationship to student:_____

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*For staff use only:

1. Medication received in clinic:
   Date_____Qty:_____Initials:_____
2. Medication received in clinic:
   Date_____Qty:_____Initials:_____
3. Medication received in clinic:
   Date_____Qty:_____Initials:_____
4. Medication received in clinic:
   Date_____Qty:_____Initials:_____
5. Medication received in clinic:
   Date_____Qty:_____Initials:_____
6. Medication received in clinic:
   Date_____Qty:_____Initials:_____