

REQUEST TO ADMINISTER MEDICATION

I request that designated personnel of Round Rock ISD administer the medication listed below to my child according to the label and/or physician instructions. I agree to furnish an adequate amount of medication in the original container. I understand that Round Rock ISD personnel will protect my child and not administer medication if this form is not completed or the medication is not furnished as required.

Please note: Non-Prescription/Prescription Medication cannot be sent home with the Student

At the end of the school year (check one): Dispose of medication Parent will pick up

*******Note: All remaining medications will be disposed of on the last day of school*******

See back for more detailed information.

Call your campus clinic at: _____ Completed requests can be faxed to: _____

Prescription Medication

Name of Student: _____ DOB: _____ Age: _____ Grade: _____ Teacher: _____

Name of Medication: _____ Exp. Date: _____

Dosage: _____ **Route:** _____ **Time:** _____ **OR CIRCLE ONE: 11am - 1pm 12pm - 2pm**

(Please note medication ordered "at lunch" is considered 12:00pm.)

Condition for which the medication is prescribed: _____ Do not administer after the following date: _____

Side effects: _____

Physician's Printed Name: _____ Physician's Signature: _____

Physician's Telephone: _____ Physician's Fax: _____ Date: _____

I understand that the School District, the Board and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medication to a student, provided such administration conforms to the requirements of this policy.

Parent/Guardian Printed Name: _____ Parent/Guardian Signature: _____

Best Phone Number: _____ Email: _____ Date: _____

Non-Prescription Medication

Name of Student: _____ DOB: _____ Age: _____ Grade: _____ Teacher: _____

Name of Medication: _____ Exp. Date: _____

Dosage: _____ **Route:** _____ **Time (and or time frame) to be given at school:** _____

Do not administer after the following date: _____

I understand that the School District, the Board and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medication to a student, provided such administration conforms to the requirements of this policy.

Parent/Guardian Printed Name: _____ Parent/Guardian Signature: _____

Best Phone Number: _____ Email: _____ Date: _____

MEDICATION PROCEDURES

Prescription and over the counter medication may be administered at school if the following apply:

1. Approved authorization forms are on file for medication to be administered. A new completed form is required each school year.
2. **Medication must be provided by the parent or guardian. No medication is provided by the school except for Benadryl and/or epinephrine in case of a possible anaphylactic reaction.**
3. Medication must be kept in the school clinic and administered by the school nurse, health assistant or school employee.
4. **No medication will be sent home with a student.** Parents/Guardians must pick up all medications whether prescription or over-the-counter.
5. Over-the-counter medication must be in the original bottle or box with the label intact and non-expired. **Dispensing directions regarding age, dose and frequency will be strictly adhered to.** Request to alter the standard dosage or frequency on over-the-counter medication must be accompanied by a physician's written note and signature.
6. Prescription medication must be in the original container and non-expired. All prescription medications must be properly labeled in a prescription bottle/box with the student's name, medication name, directions for dispensing the drug and written and signed by a physician licensed to practice in the United States. **All prescription medications need a physician signature and a parent/guardian signature. This includes daily, as-needed, and short-term medications. Any change in dosing will require a new order accompanied by physician signature and parent/guardian signature. NO PRESCRIPTION MEDICATIONS WILL BE GIVEN WITHOUT A PARENT/GUARDIAN AND PHYSICIAN SIGNATURE.**
7. Medications (controlled substances) will be counted by the school nurse or the health assistant upon arrival at school and documented as to the number of pills received. Medications must be delivered by the parents/guardians.
8. Medications prescribed or requested to be given three times a day or less will not be given at school unless a specific time of administration during school hours is prescribed by a physician.
9. A student may be allowed to self-administer inhaled asthma medication, an Epi-pen, or diabetes treatment ONLY if the following conditions have been complied with:
 - a. Written permission from the physician allowing the student to self-medicate or treat
 - b. The nurse has counseled the parent and the student on the school's inability to monitor the student's health condition during the school day while self-medicating or treating.
 - c. The student complies with all campus safety policies.
10. No district employee will administer herbal substances, anabolic steroids or dietary supplements except as provided in RRISD Policy: FFAC (local). Herbal substances or dietary supplements may be administered as prescribed by a physician if it is required by the IEP or Section 504 plan of a student with a disability. Medication must be provided by student's parent or guardian. Reliable information must be given by the physician regarding the safe use of the product including side effects, toxicity, drug interactions and adverse effects.

*****In accordance with the Nurse Practice Act; Texas Administrative Code, Section 217.11, the Registered Nurse and the Licensed Vocational Nurse have the responsibility and authority to refuse to administer medications that, in the nurse's judgment, are contra-indicated for administration to the student.*****