2021 - 2022 KATY ADVENTIST CHRISTIAN SCHOOL

Permission to Administer Medication

Parents: Complete this form and return to the Office with the medication to be given.

I hereby request and grant permission to the Katy Adventist Christian School. to administer medication to my child. If the school administrator / nurse deems it necessary, I also grant the school administrator / nurse permission to notify my child's teacher(s), either verbally or in writing, of this medication and of possible reactions that might occur. I further state that this medication cannot be scheduled for other than school hours. I understand that oral medication, inhalers, nebulizers and oxygen administration may be given by a medically untrained designate of the principal as per Texas Education Code, Section 22.052.

Student's Name: _____ Grade: _____

Condition for which medication is to be given: _____

Name of Medication	Dosage	Time for Each Dosage *(Non-prescription drugs cannot be given **"as needed"** except by a doctors order)*
1.		
2.		
3.		

Special Instructions; if any _____
Date Requested: _____ Date of Termination: _____

_____ _____
Telephone Number Parent's Signature

_____
Email Address

I wish my child's medication to be sent on Field Trips. ☐ **yes** ☐ **no**
Initial appropriate box

School has my permission to give the AM dose when it is not given at home. ☐ **yes** ☐ **no**
Initial appropriate box

I wish to be notified prior to giving the missed dose. ☐ **yes** ☐ **no**
Initial appropriate box

I wish my child's medication to be sent home with him/her on the last day of school ☐ **yes** ☐ **no**
Initial appropriate box

PLEASE NOTE THE FOLLOWING MEDICATION POLICIES

1. All medication must be in its original container and be properly labeled. The pharmacy label must state the student's name, medication, dosage, doctor's name, and date prescription was filled. **The prescription is to be current within the last 12 calendar months**. Non-prescription drugs should have the student's name affixed to the original bottle, and the doctor's orders.
2. After five (5) consecutive school days, students on non-prescription drugs will be required to submit a physician's authorization for continuance of medication.
3. Any unused medication left over two weeks after the last dosage will be destroyed.
4. Changes in prescription medications require either a **new** prescription labeled bottle or written physician request for dosage change. A new parental permission request is to accompany any change in medication.
5. It is requested that medication be brought to the office by the parent and given to the school designated person. No medication will be transported by any school transportation service personnel.
6. Vitamins, minerals, diet supplements, and special diets will not be administered by school staff except from a physician's written order.

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CONSENT TO TREATMENT

Only designated staff will have access to the completed form. This form will be stored in a locked file.

This form must be filled out at the beginning of each school year to cover the activities for the school year. A copy of each student's form must be taken on off-campus activities.

Student's Name _____

Age _____ Date of Birth _____ Social Security Number _____
Mo. Day Year

Address _____

Parent/Guardian's Name _____

Father/Guardian _____ _____ _____
Business Telephone Home Telephone Social Security Number

Mother/Guardian _____ _____
Business Telephone Home Telephone Social Security Number

Please describe allergies to substances and medication. _____

If on regular medication, please specify _____ Date of last tetanus shot _____

Please give the name of your local family physician(s) to be called in case your son or daughter becomes ill or has an accident at school and you cannot be reached.

1. Family Physician _____ Office Telephone _____

Address _____

2. Family Physician _____ Office Telephone _____

Address _____

Hospital preference _____ Telephone _____

Please give the names of two relatives or friends who have consented to assume the responsibility of your son or daughter in case of illness or accident until you can be reached. In case of any changes in the named persons, notify the school in writing.

1. Name _____ Telephone _____

Address _____

2. Name _____ Telephone _____

Address _____

If emergency service involving medical action or treatment is required and neither the parent nor the family physician can be reached for consent, the parents hereby consent to the rendering of such emergency medical service for the above named student as shall be necessary in the medical opinion of the doctor rendering the service. This authorization is given pursuant to the local state Civil Code.

Signature of Parent or Guardian _____ Date _____

Please Complete Opposite Side Also