Revised August, 2015

Hudson Independent School District

Student Health Information and Medication Consent Form

Student Information

Student Last Name:	First Name:	(Circle) Male / Female	Birth Date:	Grade	Campus

Father's Name:	Home Phone:	Work Number:	Cell Number:
Mother's Name	Home Phone:	Work Number:	Cell Number:
Emergency Contact:	Home Phone:	Work Number	Cell Number:

Student's Medical Information and History

Student's Doctor: Phone#:	Hospital Preference: (Circle) CHI Memorial / Woodland Heights

Does student have any allergies to Medication: ___YES / NO_____ If YES please list medications:_____

_____

_____

Has student ever been diagnosed or been prescribed any of the following:

Illness:	Yes	No	Illness:	Yes	No
Allergies			Asthma		
Diabetes			Heart Conditions		
Vision			Hearing		
Glasses			Hearing Aids		
Attention Deficit Disorder (ADHD/ADD)			Other: Please List _____ _____		

Please list any and all medications including inhalers and nebulizers:

_____ _____

_____ _____

Please explain any other health concerns:_____

_____

Medical Authorization

If necessary, I hereby consent to emergency medical treatment for my child, as well as authorize health related information to be released to the appropriate district staff for the care, safety, and welfare of my child.

Signature of Parent or Guardian: _____ Date:_____

Permission for Administration of Medication

PARENTS,

In order to comply with the Texas Education Agency's recommendations and Local School Board Policy FFAC (LOCAL), the below procedures will be followed for administration of medication to a student.

1. **Only those school personnel authorized by the Superintendent may administer medication to students.**
2. **Authorized school personnel may administer BOTH prescription and nonprescription (over-the-counter) medications in accordance with local district policy FFAC.**
3. **Prescription medication may be administered for a period of up to ten days; a written request by a physician or other health-care professional with authority to write prescriptions shall be required when the medication must be administered for a longer period of time.**
4. **Prescription medication must be properly labeled and in the original container. A proper prescription label contains the following information: Student's name, date, physician's name, physician's directions for administration, and name and strength of medication.**
5. **All student medication prescribed by a physician must be accompanied by a signed and dated note from a parent or guardian requesting the medication be given at school.**
6. **Over-the-counter medication provided by the parent may be administered to the student upon a parent's written request when properly labeled and in the original container.**
7. **Over-the-counter medication provided by the District may be administered only by authorized school personnel and in accordance with a consulting doctor's standing order. *See* Hudson ISD Board Policy FFAC (Local).**
8. **A list of all medications provided by the District is included below. Parents are given an opportunity below to consent to the administration of each nonprescription medication, individually.**
9. **Anytime over-the-counter medication provided by the District is administered to a student, notice to the parents will be sent home with the student.**

NO MEDICATION (PRESCRIPTION OR OTHERWISE) SHALL BE ADMINISTERED TO THOSE STUDENTS WHO DO NOT HAVE A CURRENT SIGNED STUDENT HEALTH INFORMATION AND CONSENT TO TREATMENT FORM ON FILE IN THE NURSE'S OFFICE AND THE ABOVE PROCEDURES FOLLOWED!

Over-the-Counter Medications Provided by District

Please check any of the following over the counter medications you consent for Hudson I.S.D. trained professional to administer:

Medication:	Yes	No	Medication:	Yes	No
Vaseline			Bactine Spray		
Hydrogen Peroxide			Rubbing Alcohol (91%)		
Triple Antibiotic			Tylenol		
Motrin			Aleve (if age appropriate)		
TUMS			Hydrocortisone cream (1%)		
Benadryl			Sting Kill		
Claratin			Lamisil		
Zyrtec			Peptobismol		

If necessary, I hereby consent to the administration of the above marked non-prescription, over-the-counter medication for my child and understand that after three consecutive days of receiving OTC medicines my child will need to be seen by a doctor:

Parent/Guardian Signature: _____ Date: _____

Emergency Medication Authorization

Under the districts supervising physicians, Hudson I.S.D. provides the following emergency medication:

Medication	Yes	No	Medication	Yes	No
Albuterol Solution for Nebulizer			Epi-Pen or Epi-Pen Jr.		
Glucagon			Oxygen		

If necessary, I hereby consent to the administration of the above marked prescription medication for my child:

Parent/Guardian Signature: _____ Date: _____