Wheeler Independent School District
#1 Mustang Drive   PO Box 1010
Wheeler, TX 79096
Lanette Hastey, School Nurse
806-826-5934

Parent/Guardian Authorization of Medication at School
(Complete one form for each medication)

Student Name: ____ DOB: ___-___-___ Student Id: ________________

Grade: ________________ Teacher: ________________________________

Only those medications that are medically necessary during school hours for a student's attendance or written in an IEP should be sent to school. Wheeler ISD requires the following:

- Parent/Guardian written authorization for medication administration at school
- Medication in the original, properly labeled container (name of medicine with strength, dosage, and directions; name of prescribing physician who is licensed in TX; current date)
- Medication label contains the student's first and last name
- Non-prescription/Over-the-counter medications may be available in the nurse's office with parent authorization.
- The first dose of this medication for the current condition/illness **may not be given at school**.

Please complete the following:

Medication Name and Strength (only one medication per page)	Dosage	Time(s) to be given at School	How is it Taken (mouth, eye, ear, nose, tube, on the skin, etc)	Reason/Medical Condition for which Medication is given	Medication expiration date	Additional Comments

Medication Start Date: ______________________________ Medication Stop Date: ___________________________________

(NOTE: THE FIRST DOSE OF ANY MEDICATION MAY NOT BE GIVEN AT SCHOOL)

Has the student ever received this medication before: ________ Yes _______No

If YES, Date and Time last dose given ____

1. I request that the above medication be given during school hours as ordered by this student's physician, I also request that the medication to be given on field trips, as prescribed with adequate notification from me.
2. I release school personnel from liability in the event adverse reactions result from taking the medication.
3. I will notify the school of any change in the medication, (dosage change, time change, etc.).
4. I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action(s) of the medication.
5. I give permission to the school nurse to consult with the above student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by the medication.
6. I give permission for the medication to be given by a trained school personnel as delegated by the Principal.

Please Note: Elementary school students may not carry medication home ((with the exception of inhalers); all medication must be transferred from adult to adult.

I understand I am responsible for retrieving the medication from the School Health Office when it is no longer needed or when the school year ends.

Parent/Guardian Printed Name	Day/Cell Phone Number	Alt Phone Number
Parent/Guardian Signature	Day/Cell Phone Number	Alt Phone Number

Reviewed by RN_________________Designee__________________ may/_______ may NOT administer this medication

RN Printed Name: ____ RN Signature: _________________________________