

Anna Independent School District

Physician Prescription Medication Permission Form: Secondary

This form is valid for one school year

Student Name: _____ **DOB:** _____ **Drug Allergies:** _____

Condition/s for medication to be given at school _____

Medication	Expiration date	Dosage in mgs	Time/frequency/route	Indications to give
1.				
2.				
3.				

List any special instructions/precautions/side effects of medications: _____

Is this the first dose of a new medication for your student? YES or NO

****Anna ISD does not administer vitamin, herbal, home remedy, or non-FDA approved medications. Medications will be administered for two weeks while waiting for physician signature. Medication must be prescribed by a **Texas** physician, however, will be administered for two months to allow for students new to Texas to obtain a new physician and orders.*

****Only those medications that cannot be given at home will be administered during the school day. Once, twice, and three times daily, medications will not be given at school, unless other arrangements have been made with the School Nurse.*

****While a reasonable attempt will be made to remind the student, it is the student's responsibility in most cases to remember to come to clinic to take medications.*

Physician Signature _____

Printed Physician Name: _____ Date: _____

Office phone #: _____ Fax # _____

I authorize Anna ISD to administer above medication/s to my child and understand that a designated employee may administer medications if the nurse is unavailable. I also authorize the AISD nurse to contact physician to clarify medication orders and discuss effects and conditions, if needed. Medication not picked up at the end of the school year will be destroyed.

Parent Signature: _____ Daytime phone: _____

