Brackett ISD

MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY THE PARENT/GUARDIAN

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Name of Medication: _____

Reason for Medication: _____

Time and dose to be given at school: _____

Length of time this medication should be given: _____

I give permission for the above-mentioned student to receive the medication listed on campus, per school policy.

Parent Signature: _____ Relationship: _____ Date: _____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Medication Name: _____ Dose: _____

Reason for Medication: _____

Time to Administer: _____ Route: _____

Length of time treatment should be given: _____

This student is both capable and responsible for self-administering this medication:

NO _____ YES, **SUPERVISED** _____ YES, **UNSUPERVISED** _____

The student may carry this medication: NO _____ YES _____

Health Care Provider's Name: _____

Providers Signature: _____

*For student safety, all medication should be brought to the health office by the parent. *
*All medication must be in its original, properly labeled container. *
*Medication that has expired or is not picked up by the parent will be destroyed. *

Please return via fax or email to District Nurse at (830) 867-2054 or
taryn.courneen@brackettisd.net isabel.rivas@brackettisd.net Health Aide