

The following guidelines apply to medication administered at school:

1. Due to the number of students on campus and the volume of medication distribution involved, medications should be given at home whenever possible.
2. **Narcotics cannot be administered.**
3. Medications may be given by an unlicensed person.
4. **A parent or guardian should bring the medication to the clinic in case clarification or special directions are needed.**
5. **The first does of any medication must be given at home to observe for adverse reactions.**
6. **All medication administration requires a parent signature.**
7. **A physician signature is required.**
8. Medications must be kept in a locked cabinet. **Do not put a dose in a lunch box or backpack for self-administration.**
9. **Medications must be in the original labeled container and labeled in English. Only medications approved for use in the United States will be given.**
10. **Send only the amount of medication needed at school. No extra medication can be sent home with students.**
11. Unused medication must be picked up by an adult the last day of school or it will be destroyed.
12. Expired medication not picked up by an adult the last day of school will be destroyed.
13. Homeopathic medication, dietary supplements, herbal supplements and essential oils will not be given.

By my signature, I request that this medication be given by a school employee. I acknowledge that I will not hold A. W. Brown Leadership Academies, the Board of Trustees, and/or District employees liable for damages resulting from administration of this medication.

Parent/Guardian Authorization for School Staff to Communicate Health Information: I authorize the District’s designees, including District medical professionals and UAPs, to share/obtain my scholar’s health related information with the medical health professional of Healthcare provided identified to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student’s IHP, 504 plan, IEP or other AISD form requesting for school health services. By signing this Authorization, I readily acknowledge that the information used of disclosed pursuant to the Authorization may be subject to re-disclosure by designees authorized here-in and the person(s) with whom they communicate, and no longer be protected by HIPPA rules. I hereby release my Health Care provider that acts in reliance on this Authorization from any liability that may accrue from releasing my scholar’s individually identifiable Health Information. School related health services described herein shall not be provided to a scholar without the required consent of the parent/guardian, as outlined herein.

Parent signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

Mobile phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMATION BELOW THIS POINT MUST BE COMPLETED IN ENGLISH**



*One medication per form only*

Physician signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition for which medication is being given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_