Reset Form

May Independent School District

Medication Authorization Form

THIS FORM MAY ALSO BE FOUND ON MAY ISD WEBSITE UNDER NURSE FORMS

NAME OF STUDENT _____ Date _____
School _____ Grade _____

I, _____, hereby request and authorize the staff of May ISD to dispense and/or monitor the medication as prescribed by Dr. _____for my child _____ beginning _____ and ending, _____or for episodic/emergency events only _____.

I agree to hold harmless May ISO and its employees for any consequences resulting from administration of medication.

REASON FOR MEDICATION _____
NAME OF MEDICATION, PRESCRIPTION# AND DIRECTIONS:
_____
_____

FORM OF MEDICATION:
_____ Tablet/Capsule _____ Liquid _____Inhaler _____Other _____

SPECIAL INSTRUCTIONS: (i.e.: before or after meals (breakfast and/or lunch), with food, no milk, etc.)
_____
SPECIAL STORAGE REQUIREMENTS: _____ NONE _____ REFRIGERATE

STUDENT IS CAPABLE AND RESPONSIBLE FOR SELF-ADMINISTRATION:
_____NO _____YES-SUPERVISED _____YES-UNSUPERVISED

ALLERGIES: _____
other medications your child is taking: _____
PLEASE INDICATE IF THERE ARE ANY EXPECTED SIDE EFFECTS:
_____
_____

PARENT/GUARDIAN: _____ _____
(Print Name) (Signature)
ADDRESS: _____

PHONE: HOME _____ WORK_____ CELL _____
I understand that all medication left at the school after the last school day will be destroyed. I further am aware that it is my responsibility to provide timely medication refills if the student is to continue taking medication at school. _____
(initials)