San Marcos Consolidated Independent School District
Authorization for Medication Administration
2025-2026

School:_____ School Phone: _____ School Fax: _____
Student Name: _____ Birth Date: _____
Name of Parent/Legal Guardian and Contact Information: _____
Student ID: _____ Grade: _____ Teacher Name: _____
Student's Physician: _____ Phone: _____ Fax: _____
Medication Allergies: ____ NKDA ____ Allergic to: _____
Medication: _____ Dosage: _____
Route: _____ Time(s) to be administered at School: _____
Dates to be administered: _____ or _____ Entire School Year
If as needed, describe indication: _____
May repeat as needed dosing after: _____
Condition for which the medication is required: _____
Has the child ever taken this medication before: _____ Yes _____ No
Special instructions or known side effects: _____

Parent or Legal Guardian Authorization

I am the parent or legal guardian of the above-named student and am authorized to consent to his/her medical treatment. I understand that all medication(s) must be in the original container and must be provided by the parent(s) or guardian(s). All medications must be kept in the nurse's office unless the student is cleared by both the physician and school nurse to self carry for the following medical conditions: asthma, allergic reactions or diabetes. All narcotics/scheduled medications must be kept in the nurse's office at all times. All medication will be administered according to the medication policy FFAC. First doses of medications shall not be given at school. No more than a 30 day supply of medications may be kept on campus.

Prescription medications require both a signed physician order and parent written request.

Over the Counter medications require both a signed physician order and parent written request.

I authorize the physician named below to release information regarding medication(s) my child will take during school hours, to San Marcos CISD Student Health Services. I authorize San Marcos CISD Student Health Services to notify and/or speak with the physician named below regarding any concerns or questions regarding this medication. I give permission for photographs to be taken of my child to be used on the medication bottle and log.

I request that the designated personnel of San Marcos CISD administer medication to my child, named above, according to **written physician instructions** and for the school nurse to exchange information with the physician regarding medication and health related issues. I understand it is my parental responsibility to furnish an adequate supply of this medication in the original and properly labeled container. I will notify the school immediately if the health status of my child changes, a change in physicians, or the medication is changed or discontinued. I understand that school district personnel will protect my child by not administering the medication if this form is not complete or the prescribed medication is not provided. I understand that the School District, the Board and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medication to a student, provided such administration conforms to the requirements of this policy.

Parent/Guardian Name: _____ **Signature**: _____ **Date**: _____

Physician Authorization Required:

I verify the above medication information is accurate and needs to be administered during school hours for the student listed.

Physician Signature: _____ **Printed Name:** _____**Date**: _____

Medication Log

Date: _____ Med Count: _____ Parent Initials: _____ Staff Initials: _____

Date: _____ Med Count: _____ Parent Initials: _____ Staff Initials: _____

Date: _____ Med Count: _____ Parent Initials: _____ Staff Initials: _____

Date: _____ Med Count: _____ Parent Initials: _____ Staff Initials: _____

Date: _____ Med Count: _____ Parent Initials: _____ Staff Initials: _____

Date: _____ Med Count: _____ Parent Initials: _____ Staff Initials: _____

Date: _____ Med Count: _____ Parent Initials: _____ Staff Initials: _____

Date: _____ Med Count: _____ Parent Initials: _____ Staff Initials: _____

Medication Pick Up

End of Year Count: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Staff Comments: _____

_____

_____