



Physician and Parent Authorization for Long Term (**greater than 10 days**)
Prescription and Non-Prescription Medications

Student: _____ **DOB:** _____

School/Campus: _____ **Grade:** _____

Physician's Order

Medication: _____ **Dose:** _____ **Route:** _____

Directions/times medication to be given at school: _____
(For PRN orders please specify how often as needed) (For routine orders please specify time to be given at school)

Diagnosis/reason(s) for medication : _____
(Medications will not be administered for any reason other than what is listed. Please be specific)

Restrictions/Special Instructions: _____

Pertinent Medical History: _____

Physician's Signature

Date

Printed Name of Physician

Office Phone Number

Office Fax Number

Has student taken this medication before? Yes No *(Initial dose must be given at home)*

Does student have food/medication allergies? No Yes **List:** _____

Parent should make every effort to schedule student's medication in a manner that keeps medication administration in school at a minimum. Medications to be given three times a day or less are not to be given at school unless a specific time during school hours is prescribed or the medication is on an "as needed" basis.

I _____ give permission for Comal ISD school personnel to give the listed medication to the above named student during school hours. I understand per Section 22.052 (2) of the Texas Education Code that the school district, its board of trustees and its employees are not liable for damage or injuries resulting from the administration of this medication. In addition, the licensed school nurse has the responsibility and authority to refuse to administer medications that, in the nurse's judgment, are not in the best interest of the student. (Board of Nurse Examiners Rule, 22 Texas Administration Code 217.11).

Parent/Guardian Signature

Date

Emergency Contact Phone Number(s): _____