

- Business, Education, Technology Academy
 Rising Scholars Academy of South Texas
 South Texas Academy for Medical Professions
 The Science Academy of South Texas
 South Texas Preparatory Academy
 South Texas High School for Health Professions

MEDICATION ADMINISTRATION PARENT PERMISSION FORM FOR TEMPORARY MEDICATIONS

TO/PARA: Vivian Galloso, RN SCHOOL NURSE/ENFERMERA ESCOLAR

I request the school to administer provided medication to: _____ Name of Student / Nombre de Estudiante _____ D.O.B/ Fecha de Nacimiento ID # _____ Name of Doctor / Nombre de Doctor _____ Diagnosis / Reason for Medication <i>Diagnostico / Razon por Medicamento</i> Effective Dates / Fechas Efectivas: _____ - _____ Beginning / Comienzo Completion/Completacion	MEDICATION(S) / MEDICAMENTO(S)	
	_____ Name of Medicine/ Nombre de Medicina	_____ Name of Medicine/ Nombre de Medicina
	_____ Form of Medication/Tipo de Medicamento	_____ Form of Medication/Tipo de Medicamento
	_____ Dosage / Dosis	_____ Dosage / Dosis
	_____ Time / Hora	_____ Time / Hora
	Other information / Otra informacion: _____ _____ Special storage Requirements / Requerimientos para guardado especial: _____ _____	

The medication should be delivered to the nurse, principal, and/or teacher by the parent or responsible adult. It should be in a properly labeled container (prescribed or not) with the student's name, physician's name, date of original prescription, name of medication, and instructions on frequency of medication. Over the counter medications should be in unopened container. If a medication is needed for more than 4 weeks, a written statement from the prescribing physician detailing medication administration must accompany this request.

El medicamento debe ser entregado a la enfermera, director y / o maestro por el padre o adulto responsable. Debe estar en un recipiente correctamente etiquetado (prescrito o no) con el nombre del estudiante, nombre del médico, fecha de la receta original, nombre de el medicamento e instrucciones sobre la frecuencia de la medicación. Sobre los medicamentos de venta libre deben estar en contenedores cerrados. Si se necesita un medicamento durante más de 4 semanas, debe acompañar esta solicitud una declaración escrita del médico que prescribe que detalle la administración del medicamento.

I, _____, authorize the school to assist our child in taking medication and agree that I will not hold liable any member of the school staff or an individual of official capacity.

Parent/Guardian Signature **Phone Number** **Date**

Yo, _____, autorizo a la escuela a ayudar a nuestro niño a tomar medicación y estoy de acuerdo que no responsabilizaré a ningún miembro del personal de la escuela ni a un individuo de capacidad oficial.

Firma de Padre / Tutor **Numero de Telefono** **Fecha**

NOTE: To avoid delay in the student receiving important medication, the school nurse should have parent/guardian sign this form on day Rx is brought to school. If long-term medication is needed, **Long-term** form will be given to parent/guardian for physician's statement and returned as soon as possible.