See the following forms regarding administering medication and emergency health care to students:

Exhibit A: Request for the Administration of Medication at School—2 pages

Exhibit B: Authorization to Secure Emergency Medical Treatment of a Student—2 pages

Exhibit C: Authorization for Self-Administration of Asthma and/or Anaphylaxis Medication—1 page

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Note: Sample medication logs can be found in Chapter 5 of the Texas Department of State Health Services' *Texas Guide to School Health Programs* at http://www.dshs.state.tx.us/schoolhealth/shpguide/chap5.pdf.

EXHIBIT A

REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

Date form was received by the school: _____

Student's name: _____

Date of birth: _____ Grade: _____

Teacher/Classroom: _____

Name of medication: _____

Reason for medication: _____

Form of medication/treatment: _____

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer

☐ Other: _____

Instructions (schedule and dose to be given at school):

Start: ☐ Date form received ☐ Other date: _____

Stop: ☐ End of school year ☐ Other date: _____

Restrictions and/or important side effects:

☐ None anticipated

☐ Yes *(Please describe)* _____

Special storage instructions:

☐ None ☐ Refrigerate ☐ Other: _____

Physician information:

Name: _____

Address: _____

Phone number: _____

Physician's signature: _____ Date: _____

[To be completed by the parent or guardian.]

I give permission for _____ *(student's name)* to receive the above medication at school in accordance with District policy. [See FFAC]

_____ _____
Signature of parent or guardian Date

[Developed using resources from the American Academy of Pediatrics and Texas Department of State Health Services]

EXHIBIT B

AUTHORIZATION TO SECURE EMERGENCY MEDICAL TREATMENT OF A STUDENT

Student's name: _____

Date of birth: _____ Grade: _____

Name or parent or guardian: _____

Address: _____

Work phone: _____ Home phone: _____

Mobile phone: _____

Local person to contact if parent or guardian cannot be reached:

Name: _____

Phone: _____

Relationship to the student: _____

Student's physician or other preferred health-care provider:

Name: _____

Phone: _____

Student's dentist:

Name: _____

Phone: _____

Medications or drugs to which the student has had an allergic or adverse reaction:

_____

Part 1:

I hereby authorize the Superintendent of McLean Independent School District or a designated representative to secure any and all emergency medical care and treatment for _____ *(student's name)* for acute illness suffered, injury sustained, or other situation requiring emergency medical treatment while at school or participating in school-related activities. I prefer that emergency treatment be secured at _____ *(indicate preferred medical facility)*; the District may use another licensed hospital, clinic, or medical facility, if necessary, with the following exceptions: _____.

I understand that cost of services provided by ambulance, private physician, clinic, hospital, or dentist remains the responsibility of the parent or guardian and will not be assumed by the District or any of its officers or employees.

☐ I do have medical insurance coverage on my child with:

_____.

☐ I DO NOT have medical insurance coverage on my child.

_____ _____

Signature of parent or guardian Date

EXHIBIT C

AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA
AND/OR ANAPHYLAXIS MEDICATION

Note: For information addressing students at risk for anaphylaxis, see FFAF.

Student's name: _____

Date of birth: _____ Grade: _____

Name of parent or guardian: _____

Address: _____

Work phone: _____ Home phone: _____

Mobile phone: _____

Prescribing physician or health-care provider:

Name: _____

Phone: _____

Description of condition/reason for medication: _____

_____

Prescribed medication and dosage: _____

How/when the medication should be used at school *(dosage, method, times)*: _____

_____

Anticipated length of treatment: _____

Possible adverse reaction: _____

_____ *(student's name)* has asthma and/or anaphylaxis and is treated with prescription medication. He or she is capable of administering his or her own medication at school and at school-related or school-sponsored activities. The District will be informed of any changes to the medication specified on this form, to the dosage, or to the recommended regimen by an updated version of this consent form.

_____ _____
Signature of parent or guardian Date

_____ _____
Health-care provider's signature Date