Albany ISD Health Services
Authorization/ Parental Consent for Administering Medication

(Use a separate authorization form for each medication)

Student's Name ____ **Date of Birth**________________

Allergies: ____

Parental Consent:
I am the parent or guardian of _________________________________. I give my permission for him/her to take the following medication while in Albany Independent School District. I hereby acknowledge that I have read and understood to School Board Regulations relating to the taking of medications. I hereby release Albany ISD and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the licensed prescriber.

_______________________________________ __________________________ _____________________

Parent or Guardian Signature Daytime Phone # Date

Medication Authorization (Over the Counter Medication)

Relevant Diagnosis____________________________ Medication _____________________________________

Dates to be given at school: ☐ Every day at school ☐ Episodic/Emergency Events

☐ Short Term (Dates to be given)_______________________________

Dosage(Amount)_________________ Route ______________ Form____________Times____________

****To be completed by parent/guardian****

Medication Authorization (Prescription Medication)

Relevant Diagnosis____________________________Medication______________________________________

Dates to be given at school: ☐ Every day at school. Times to be given:_______________________

☐ Episodic/Emergency Events. Describe________________________

____

☐ Short term (dates to be given)______________________________

Dosage _________________________ Route ________________ Form ______________________

Licensed Prescriber Name ____

Phone Number ____________________________________ Fax Number _______________________________

Licensed Prescriber Signature:_______________________________________**Date** ______________________

****To be completed by physician****