

Medication Dispensing Permission Form

Complete one form for each medication.



Student Name: _____ Birth Date: _____ Campus: Bissonnet Museum District

The Post Oak School will administer medication to children for whom a plan has been made. **Only those medications that are medically necessary during school hours for a student's attendance or written in a plan should be sent to school.** The Post Oak School requires the following:

- Parent/Guardian written authorization for medication administration at school.
- Medication must be in original, child-proof container and labeled with child's first and last name.
- When no longer needed by the child, or when the child withdraws from the school, all medications will be returned to the child's parent or guardian or disposed of after attempt to reach parent/ guardian.
- If a **liquid oral medication** is to be administered, the parent/ guardian must **provide administration device with clearly marked measurements** (medicine sip-vial, medicine cup, dropper, or syringe).
- The **first dose** of the medication for the current condition or illness **may not be given at school.**
- Medication must be in the original, properly labeled container (name of medicine with strength, dose, and directions; for prescription medications, the container must have the name of the physician who is licensed in Texas.)
- Instructions from the child's parent/guardian shall not conflict with the label directions as prescribed by the child's health care provider.
- Non-prescription medications may be administered without approval from the child's health care provider.
- Non-prescription medication will be administered per product label directions on the container.
- Instructions from child's parent or guardian shall not conflict with prescriber's or product directions on the label.

Please Complete the following:

Medication name and strength	Dose	Time (s) to be given at school	Route/ how it is taken	Reason(s)/ for which it is indicated	Expires

Medication Start Date: _____ Stop Date: _____

Has this student ever received this medication before? Yes No Date and time of last dose given: _____

PARENT/GUARDIAN STATEMENT

I request that the above medication be given during school hours as ordered by this student's physician. I also request that the medication be given on any off-campus field trips, as prescribed, with notification from me. I release school personnel from liability in the event of adverse reactions resulting from taking the medication. I will notify the school of any change in the medication (dosage, time, etc.) I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action(s) of the medication. I give permission for the school nurse to consult with the above student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by the medication. I give permission for the medication to be given by trained school personnel as delegated by the head of school.

Please Note: Bissonnet students may not carry medication into or out of the building; all medication must be transferred from adult to adult at the front offices. I understand I am responsible for retrieving medication for the nurse when it is no longer needed, when it expires, or when the school year ends.

Parent/guardian name: _____

Parent/guardian signature: _____

The Post Oak School | www.postoakschool.org

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