Sam Houston State University Charter School

COLLEGE OF EDUCATION

MEMBER THE TEXAS STATE UNIVERSITY SYSTEM

MEDICATION AUTHORIZATION FORM

Part I: To be Completed by the Parent/Guardian

We strongly encourage medications to be administered home. All new medication must be administrated at home first. I hereby authorize 6 D P + R X V W R Q 6 W D W H 6 F K R R O personnel to administer medication to my child as directed below. I agree to release, indemnify, and hold harmless 6 D P + R X V W R Q 6 W D W H 8 Q L Y H U V L W \ & K D U W H U 6 F K R R O and demand, or action039 Tw ( )Tj -0.023 Tw (be)Tjc(l4nai)1.0598 -0.l i3 Tw (be)046004B00520052004F>Tj /TT1 10.02 Tf 0.01125 Tw

Parent's Signature | Daytime Phone | Date

Part II: To be completed by a PHYSICIAN for medicine (prescription or non prescription) that is to be administered longer than 10 work days (Example: Inhalers, Epi-pens)

For Epi-pens: Emergency injections may be administered by non-health professionals. For this reason, pre-measured doses of epinephrine may be administered. It should be noted that these staff members are not trained observers; therefore, they cannot observe for the development of symptoms before administering the injection. I understand that the rescue squad will always be called when epinephrine is injected (whether or not the child manifests any symptoms of anaphylaxis). The following injection will be given immediately after report of exposure to:

_____

Indicate specific allergen and type of exposure (i.e. ingestion, skin contact, inhalation)

Check as appropriate (medication expiration date must be clearly indicated) Epi-Pen/Epi-Pen Jr

- ‘ Give the pre-measured dose by auto injection
- ‘ Repeat dose in 15 minutes if rescue squad has not arrived (2 kits needed)

Please select one of the following options (for inhalers and epi-pens only):

- ‘ I believe it is best for the V F K R R O staff to carry the medication per his/her
- ‘

‘

_____

Physician's Name and Phone Number | Physician's Signature | Date

Office Use Only

This form is ***complete and the medication is appropriately labeled.*** Initial _____ Date_____

The child _____ (has/has not) been approved to carry own Epi-Pen or Inhaler.