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****