EL PASO COUNTY
SCHOOL HEALTH SERVICES MEDICATION PERMIT
PRACTITIONER'S WRITTEN ORDER/PARENT CONSENT

If medication and/or a health care procedure is to be administered during regular school hours for illness or disability, it is necessary for the District to receive the following:

1. A Practitioner's Written Order/Parent Consent statement dated for the CURRENT school year signed by the parent, legal guardian or other person(s) having legal authority of the student AND the attending practitioner licensed to practice medicine in the State of Texas. (Exemption: U.S. Military)
2. Original container with prescription label from a registered pharmacist licensed to practice in the United States with current date, student's name, dose to be given, time(s) to be given, and medication route to be given.
3. The student is not allowed to carry his/her own medication or to self-administer the medication unless ordered by the licensed practitioner. **(Students need Parent Permission and a Written Order from a Licensed Practitioner to carry Inhalers, EpiPen and insulin pumps.)**
4. ONLY medications and/or health care procedures prescribed in writing by the attending practitioner licensed to practice medicine in the state of Texas are to be administered. The following will not be administered by any school personnel: Medication prescribed and/or purchased in foreign countries.

ALL NURSES WHEREVER EMPLOYED MUST OBSERVE THE LAW THAT REQUIRES THEM TO HAVE A WRITTEN PRACTITONER'S ORDER BEFORE THE ADMINISTRATION OF ANY MEDICATION.

AT THE END OF THE SCHOOL YEAR, ALL UNCLAIMED MEDICATION WILL BE DESTROYED ON THE LAST DAY OF SCHOOL.

TO BE COMPLETED BY THE PARENT AND RETURNED TO THE SCHOOL NURSE

Name of Student _____ DOB _____ I.D.# _____

I, _____, give my permission for my child to receive the medication(s) listed below as directed by the attending practitioner. I do hereby give my consent for the release and exchange of information contained in the medical record of my child.

☐ Yes ☐No My child has my permission to carry his/her inhaler, EpiPen, and/or insulin pump as ordered by the practitioner.

☐ Yes ☐No I give permission for my child to have his/her inhaler/medication administered by trained school personnel.

_____	_____	_____	_____	_____
Parent's/Guardian's Signature	Home Telephone	Cell Phone/Beeper #	Work Telephone	Date

TO BE COMPLETED BY A LICENSED PRACTITIONER

Diagnosis: _____

Medication #1 _____
Name Strength Dose Time (at school) Route

Medication #2 _____
Name Strength Dose Time (at school) Route

Length of Time for Present School Year: Yes ____ No ____

Are there any Restrictions/Precautions? ____Yes ____No

If yes, what and how long? _____

☐ Yes ☐No If above medication is an inhaler, epinephrine, insulin pump, or glucagon, and the student is capable of self-administration, do you recommend that this child carry his/her own medication?

Allergies – Medication/food/other: (Please list) _____

_____	_____	_____	_____
Printed Name of Practitioner	Practitioner's Signature	Telephone Number	Date

_____
FAX

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