Cypress-Fairbanks Independent School District

Parent/Guardian Consent for Administration Medication

Student name: ________________________________ Grade: ______ Date of Birth: ______________ Student ID: ______________ Allergies: ______

In compliance with CFSID Board policy FFAC (local), all medications administered by CFISD staff must be:

- **delivered to the clinic by a parent/guardian or his/her designee (responsible adult),**
- **supplied in the original container (prescription bottle with prescription label or manufacturer's packaging and will only be administered in accordance with prescriber or manufacturer's guidelines),**
- **prescribed by a medical professional licensed with prescriptive authority in the state of Texas (unless US FDA approved medication available for purchase without a prescription),**
- **US FDA approved for safety and efficacy (school nurse must verify using reputable, peer-reviewed, evidence-based medical literature and may decline administration if she/he finds the dose to exceed current best practice or the medication is otherwise potentially harmful to the recipient),**
- **and retrieved from the clinic by a parent/guardian or his/her designee (responsible adult) by the last calendar day of the current school year or the medication will be destroyed in accordance with District expectations.**

I request Cypress Fairbanks ISD personnel to administer the medication(s) listed below for the 20_____- 20_____ school year:

Parent/guardian phone: (_______)________-__________ Parent/guardian email: ________________________

Med#1______________________________	**Med#2______________________________**	**Med#3______________________________**
Exp. Date: ____________Route:_________	**Exp. Date: ____________Route:_________**	**Exp. Date: ___________Route:__________**
#1 Dose: _____________Time: __________	**#2 Dose: ____________ Time: ___________**	**#3 Dose____________ Time: ____________**
Reason: _____________________________	**Reason: _____________________________**	**Reason: _____________________________**
Date of request: ______/______/20______	**Date of request: ______/______/20______**	**Date of request: ______/______/20______**

I, ______________________________, parent or guardian of student listed above, authorize the administration of the medication listed above for the current school year and authorize the school nurse or her designee to contact the prescribing healthcare provider for any clarification regarding the requested medication administration.

Sign/Date: ___________________________	**Sign/Date: ____________________________**	**Sign/Date: ____________________________**

End of year disposition of medication: **O Retrieved by parent/guardian** **O Destroyed by CFISD staff**	**End of year disposition of medication:** **O Retrieved by parent/guardian** **O Destroyed by CFISD staff**	**End of year disposition of medication:** **O Retrieved by parent/guardian** **O Destroyed by CFISD staff**
Sign/Date: ___________________________	**Sign/Date: ____________________________**	**Sign/Date: ____________________________**

Revised 6/2023