



**JOHN PAUL II HIGH SCHOOL  
MEDICATION ORDERS AND PARENT AUTHORIZATION**

Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

School Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Nurse: \_\_\_\_\_

Condition for which medication is to be given at school and administration instructions:

*List all medications or therapies to be used for this condition. Use an additional form for other conditions*

Medication	Route	Dose	Times
1.			
2.			
3.			
4.			

Physician Signature \_\_\_\_\_ Print Name: \_\_\_\_\_

Telephone number: \_\_\_\_\_ FAX: \_\_\_\_\_ Date: \_\_\_\_\_

Valid for this school year only. Non-prescription medication cannot be given as need or after 5 school days without a physician's order.

**I request and authorize JOHN PAUL II HIGH SCHOOL to administer the above medication as prescribed. I understand that the school administrator may designate any qualified person or persons to administer this medication per Texas Education Code, Section 22.052.**

After 5 school days (5) students on non-prescription medications will be required to submit a physician's authorization for continuance of medication. At no time will a non-prescription medication be given on an as needed basis without a physician authorization.

I also authorize the school's registered nurse to consult with the prescribing physician to clarify this medication order, or in the interest of the student's health, to discuss his/her response to the prescribed medication as required by Texas Nurse Practice Act.

PARENT/LEGAL GUARDIAN SIGNATURE: \_\_\_\_\_

DAY TELEPHONE (S): \_\_\_\_\_ DATE: \_\_\_\_\_

PAGER/MOBILE NUMER: \_\_\_\_\_