



## Jubilee Academies Medical Authorization Form

Student: \_\_\_\_\_ DOB: \_\_\_\_\_

School/Campus: \_\_\_\_\_ Grade: \_\_\_\_\_

Short Term Prescription Medication Authorization (10 days or less) Authorization expires \_\_\_\_\_ (please pick up any remaining medication after the expiration date-medications left in the clinic will be disposed of).

Over the Counter/Non-Prescription Medication Authorization (for the current school year)

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Oral Inhaled Other(Circle)

Directions/times medication to be given at school:

\_\_\_\_\_ (please specify how often /when to be given at school) Reason(s) for medication :

\_\_\_\_\_ (Medications will not be administered for any reason other than what is listed. Please be specific)

Restrictions/Special Instructions: \_\_\_\_\_

Medication allergies: \_\_\_\_\_

Has the student taken this medication before?  Yes  No (Initial dose must be given at home)

I give permission for Jubilee Academies school personnel to give the listed medication to the above-named student during school hours. I understand per Section 22.052 (2) of the Texas Education Code that the school district, its board of trustees, and its employees are not liable for damage or injuries resulting from the administration of this medication. In addition, the licensed district nurse has the responsibility and authority to refuse to administer medications that, in the nurse's judgment, are not in the best interest of the student. (Board of Nurse Examiners Rule, 22 Texas Administration Code 217.11).



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Parent/Guardian Signature

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Printed Name

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Date

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Telephone Number

Physician Annual Prescription Authorization (All prescription medications are given longer than 10 school days must have a Doctor's signature).

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Physician's Signature & Date

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Order valid for the current school year

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Physicians Telephone Number