2024-2025 Farwell ISD Physician Order & Medication Authorization Form

Student's Name: ______________________ DOB:___________ Grade:_______
Allergies:____
Physician Name:______________________ Physician Phone: _______________

The Texas Board of Nursing has given guidance to school nurses and a physician order is required for the school nurse to administer any prescription and over the counter medication including tylenol, ibuprofen, tums, pepto-bismol, benadryl, neosporin, hydrocortisone cream, cough drops etc.

Physicians Order

(*for licensed physician use only)*

School Nurse may administer the following medications:

Medication: ________________________________ Dose: __________________ Frequency: _______________
Administer: by mouth_____ inhalation _____ SQ injection _____ IM injection _____ topical _____
Duration: 2024/2025 school year _____ or the following dates: ___/___/___ to ___/___/___
Special Instructions: ____

Medication: ________________________________ Dose: __________________ Frequency: _______________
Administer: by mouth_____ inhalation _____ SQ injection _____ IM injection _____ topical _____
Duration: 2024/2025 school year _____ or the following dates: ___/___/___ to ___/___/___
Special Instructions: ____

Medication: ________________________________ Dose: __________________ Frequency: _______________
Administer: by mouth_____ inhalation _____ SQ injection _____ IM injection _____ topical _____
Duration: 2024/2025 school year _____ or the following dates: ___/___/___ to ___/___/___
Special Instructions: ____

Medication: ________________________________ Dose: __________________ Frequency: _______________
Administer: by mouth_____ inhalation _____ SQ injection _____ IM injection _____ topical _____
Duration: 2024/2025 school year _____ or the following dates: ___/___/___ to ___/___/___
Special Instructions: ____

Physician's Signature _____________________________________ Date __________________

By signing below, I acknowledge that:
I give permission for the designated Farwell ISD personnel to administer this medication in accordance with the physician's instructions above. I have read and understand the Farwell ISD Medication Procedures. I give permission for the school to contact the above health care provider about the administration of this medication. I understand that the School District, the Board and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medication to a student, provided such administration conforms to the requirements of this policy
Parent/Guardian Name: ______________________ Signature: __________________ Date: ________