

EXHIBIT A

REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

In accordance with Section 22.052 of the Texas Education Code, the PECOS-BARSTOW-TOYAH Independent School District has established the following rules concerning the administration of medication to students by school employees.

Only person designated by the principal will be authorized to administer the medication. No school employee will be authorized to administer medication to a student unless the following conditions have been met:

1. A parent, legal guardian, or other person having legal control of the student has provided a written request for the administration of the medication to a student.
2. All medications are properly labeled, stating:
 - a. Name and address of the student.
 - b. Date of the prescription's issue.
 - c. Name and quantity of medication.
 - d. Direction for its use.
3. No more than a _____ supply will be maintained at one time.

I, the undersigned, request that the student named be administered the specified medication at school.

Name of student _____

Parent's signature _____

Medicine to be administered _____

Dates of administration _____ to _____

Prescription Number _____

Date _____

HEALTH REQUIREMENTS AND SERVICES:
MEDICAL TREATMENT

FFAC
(EXHIBIT)

EXHIBIT B

RECORD OF THE ADMINISTRATION OF MEDICATION

Name of student _____ Grade _____

Parent's phone number _____

Medicine _____

Dates to begin _____ Date to end _____

Dosage _____ Method _____ Time(s) _____

Prescriber or person authorizing administration _____

Possible adverse reaction _____

Person(s) authorized to administer medication _____

Date given	Time	Dosage given	Signature and title/position of employee administering medication	Comments
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EXHIBIT C

REQUEST FOR THE PROVISION OF PHYSICIAN-PRESCRIBED
SPECIAL HEALTH CARE PROCEDURES

The PECOS-BARSTOW-TOYAH Independent School District has established the following rules concerning the provision of physician-prescribed special health care services to students by school employees when such services are required for the student to remain in the school setting.

No school employee will be authorized to provide such services to a student unless the following conditions have been met:

1. A parent, legal guardian, or other person having legal control of the student must have provided a written request for the provision of the specific services and must have provided the physician's written directive for the procedures.
2. If applicable, the procedures must meet the IEP requirements of a student with disabilities.
3. Special equipment will be provided in accordance with the IEP.

Only a physician or a registered nurse may assign school personnel to perform such procedures.

I, the undersigned, request that the special procedures explained in the physician's directive be provided to the student here named. I have attached the physician's directive.

Name of student _____

Parent's signature _____

Date _____

HEALTH REQUIREMENTS AND SERVICES:
MEDICAL TREATMENT

FFAC
(EXHIBIT)

EXHIBIT D

RECORD OF THE PROVISION OF PROCEDURES

Name of student _____ Grade _____

Parent's phone number _____ Doctor's phone number _____

Prescriber of the procedure _____

Summary of procedures _____

Date to begin _____ Date to end _____

Possible adverse reaction _____

Person authorized to perform procedure _____

Date performed	Time	Signature and title/position of employee performing the procedure	Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HEALTH REQUIREMENTS AND SERVICES:
MEDICAL TREATMENT

FFAC
(EXHIBIT)

EXHIBIT E

AUTHORIZATION TO SECURE EMERGENCY MEDICAL
TREATMENT OF A STUDENT

Name of student _____ Grade _____

Date of birth _____ / _____ / _____

Name of parents _____

Work phone _____ Home phone _____

Work phone _____ Home phone _____

Address _____

Friend or relative who may know where to locate parent

Name _____

Phone _____

Student's physician or other preferred health care provider

Name _____

Phone _____

Medications or drugs to which the student has had an allergic or adverse reaction are:

Part 1:

I hereby authorize the Superintendent of Pecos-Barstow-Toyah ISD or a designated representative to secure any and all emergency medical care and treatment for _____ (student's name) for acute illness suffered or injury sustained while at school or participating in school-related activities. I prefer that emergency treatment be secured at _____ (indicate preferred medical facility); the District may use another licensed hospital, clinic, or medical facility, if necessary, with the following exceptions: _____.

I understand that cost of services provided by ambulance, private physician, clinic, hospital, or dentist remains the responsibility of the parent or guardian and will not be assumed by the District or any of its officers or employees.

I do not have do have medical insurance coverage on my child with _____ Insurance Company.

Parent's signature _____

Date _____

Part 2:

This is to certify that I authorize the Superintendent of Pecos-Barstow-Toyah ISD or a designated representative to administer to _____ (student's name):

1. Tylenol (or generic acetaminophen) if my child has a temperature of 101 or higher;
2. Benadryl (or generic antihistamine) if my child experiences a local or systemic allergic reaction such as hives, welts, severe swelling, generalized itching, or tingling of the mouth or throat; or
3. _____ (other medications specific to another emergency situation as determined by the District's medical advisor)

I understand that the District will attempt to contact me as soon as possible if such action is necessary.

Parent's signature _____

Date _____

Copies of this authorization may be presented to the admissions office of a hospital or clinic or to a physician or dentist. Other distribution will occur only within the limitations of the Family Educational Rights and Privacy Act.

EXHIBIT F

AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION

Name of student _____ Grade _____

Name of parents _____

Parent's contact information _____

Prescribing health care provider _____

Contact information for the prescribing health care provider _____

Description of condition/reason for medication _____

Prescribed medication and dosage _____

How/when the medication should be used at school (dosage, method, times) _____

Anticipated length of treatment _____

Possible adverse reaction _____

_____ (student's name) has asthma and is treated with prescription medication. (He) (She) is capable of administering (his) (her) own medication at school and at school-related or school-sponsored activities. The District will be informed of any changes to the medication specified on this form, to the dosage, or to the recommended regimen by an updated version of this consent form.

Parent _____ Date _____

Health care provider _____ Date _____