PHONE: 956.565.4620

FAX: 956.565.9112

scitech.stisd.net

900 Med High Dr
Mercedes, Texas 78570

☐ Business, Education, Technology Academy
■ The Science Academy of South Texas
☐ Rising Scholars Academy of South Texas
☐ South Texas Preparatory Academy
☐ South Texas Academy for Medical Professions
☐ South Texas High School for Health Professions

PERMISSION TO GIVE LONG TERM MEDICATION AT SCHOOL

The South Texas ISD requires that all students who need prescribed medication during school hours must do the following:

1. Present a written consent form signed by the parent/guardian.
2. Bring the medication in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by law.

Long-term medication (lasting longer than 4 weeks) may be given by nurse or trained non-medical personnel provided that the prescribing physician completes the school district's medication permission request form below.

El Distrito Escolar del Sur de Texas requiere que todos los estudiantes que necesiten medicamentos recetados durante el horario escolar hagan lo siguiente:

1. Presentar un formulario de consentimiento por escrito firmado por el padre / tutor.

2. Traiga el medicamento en envase original de prescripción, debidamente etiquetado por un farmacéutico registrado como prescrito por ley.

La medicación a largo plazo (que dura más de 4 semanas) puede ser administrada por una enfermera o personal no médico capacitado, siempre y cuando el médico que prescriba complete el formulario de solicitud de permiso de medicación del distrito escolar de esta forma.

______________________________ Student Name/ *Nombre de Estudiante*

________________ D.O.B. / *Fecha de Nacimiento*

Parent/Guardian Consent

I, __________________________, give permission for my child to receive the medication(s) below as prescribed and to self-medicate if indicated by the physician.

________________________ Parent/Guardian Signature

________________ Date

Autorizacion de Padre/Tutor

Yo, __________________________, autorizo que se le administre a mi hijo(a) el(los) medicamento(s) debajo como ha(n) sido recetado(s) y auto-medicarse si es indicado por el médico.

________________________ ***Firma de Padre / Tutor***

________________ ***Fecha***

PHYSICIAN'S STATEMENT
(To be completed by Physician)

Medical Condition/Diagnosis: ____

Medication: (1) ________________ (2) ________________ (3) ________________

Dosage: (1) ________________ (2) ________________ (3) ________________

Time to be given at school: (1) ________________ (2) ________________ (3) ________________

Length of time needed: (1) ________________ (2) ________________ (3) ________________

Are there any restrictions? Yes or No If yes, what and how long? ____________________

Other instructions: ____

May child self-administer medications? _______YES ______NO

____________________ Printed name of Physician

____________________ Physician's Signature

____________ Date