



Request for Medication Administration

Student: _____ DOB _____ Grade: _____ Campus: _____

Medication: _____ Dose: _____

Take medication: by mouth via inhaler topical (cream) injection other _____

Condition for which medication is given: _____

To be given: Entire School Year - or - The following dates: ___/___/___ to: ___/___/___

When: At the following time(s): _____ - or - As needed every _____ hours

Special considerations/side effects: _____

For Daily Medications: Yes, please administer daily medication on field trips
 No, please do not send daily medication on field trips

Other medications taken at home: _____

List any food or drug allergies: _____

**Must be signed by a
physician for any of
these reasons:**

- prescription given more than 10 school days (daily medication)
- over-the-counter more than 5 consecutive days
- over-the-counter to be given at higher than labeled dose

<p>Parent/Guardian: I give permission for district personnel to administer medication to my child in accordance with Texas Education Agency and District policies. I also acknowledge that it is the parent/guardian responsibility to maintain medication supply. Unclaimed medication will be destroyed at the end of the school year.</p>	
Signature:	Date:
Printed Name:	Phone:

<p>Physician: I request that the student receive this medication during the school day as instructed above.</p>	
Signature:	Date:
Printed Name:	Phone:

<p>School: Medication was received by:</p>		
Signature:	Date:	Quantity Received:
Printed Name:	Phone Ext.:	Expiration Date: