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: □ Routinely at the following times: _____________________ - or - □ As needed

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

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 end of school year.	
Signature:	Date:
Printed Name:	Phone:

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

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