PARENT'S REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

- All ***prescribed*** medication must be in a container labeled by the pharmacist or prescriber for named student.
- ***Non-prescription*** or ***over-the-counter*** medication must be age appropriate, in the original container (NO BAGGIES) with the label intact and the student's name clearly written.
- The medication may be administered by a medically untrained designate of the principal.
- A separate permission form is required for each medication.
- No expired medications.
- Sample medication will be accepted only with written directions from the physician.
- **All medication not picked up by the last day of school will be discarded.**

Name of Student: ___________________________________DOB______________ Grade:_______ Teacher:____________________

Medication Name: ____Strength(mg)_____________Exp date_______________

If prescribed medication: Prescription number_____________________ Prescribing Physician:___________________________

Condition for which medication is being administered: ____

Specific instructions: ____

When to give: Dosage may not exceed recommended dose without a prescription. (check one below)

_____**Daily** Time to be given____________ Dosage__________ tab cap tsp tbsp puffs vial ml (circle one)

_____**One time dose** Time to be given____________ Dosage__________ tab cap tsp tbsp puffs vial ml (circle one)

_____**As needed (PRN)** Dosage__________ tab cap tsp tbsp puffs vial ml (circle one)

_____**In the mornings when forgotten at home** (call to verify? yes or no) Dosage_____ tab cap tsp tbsp puffs vial ml (circle one)

Administer this medication until: _____end of school year or _______specific date____________________
mm/dd/yyyy

Daily prescription/OTC medications to be given for 30 days require a physician's signature

Physician Signature ____**Date**______________________

_______ **I authorize, as needed, the sharing of information regarding my child's health between the school nurse, Thrall ISD faculty/staff and the prescribing health care provider to ensure his/her health and safety during school hours.**

I request the above medication to be administered to the above named student by Thrall ISD school personnel.

Parent signature: ____ Date:_____________

Phone number__________________________________