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MEDICATION ADMINISTRATION REQUEST

When it is necessary for your child to receive medication during the school day, the following procedures must be followed:

- 1) Parents/guardians must provide all medication, and parent/guardian signature is required for all medications given at school. **Physician's signature is required for all controlled substances**, i.e. narcotic pain meds, most ADHD medications, and for medications prescribed differently from manufacturer's instructions.
- 2) All medication must be in the **original container**, clearly labeled with the student's name, the dosage and/or age-appropriate dose of medication and directions for administration. **All controlled substances must be hand delivered to the school nurse by the parent/guardian.**
- 3) The Medication Administration Request must be completed each school year and when there are any changes to the original request including a medication and/or dose change. A separate form must be completed for each medication.
- 4) Only FDA approved pharmaceuticals (prescription and non-prescription) will be administered. **Homeopathic preparations will not be accepted.**
- 5) Parents/guardians are strongly encouraged to pick up all medication immediately after it is discontinued. **AT THE END OF THE SCHOOL YEAR, ALL MEDICATION THAT HAS NOT BEEN PICKED UP BY THE PARENT/GUARDIAN WILL BE DESTROYED. NO MEDICATIONS WILL BE LEFT ON SCHOOL PROPERTY DURING THE SUMMER MONTHS.**

TO BE COMPLETED BY PARENT/GUARDIAN

I, _____, request and give permission for school personnel at _____ School to give my child, _____, the following medication according to the stated directions. I understand and agree that the school will not be held responsible for any ill effects which might occur in connection with the administration of this medication.

Medication _____ Dosage _____ or per label
Drug Allergies _____ Side effects/Precautions _____

Dates to be given: From _____ To _____

Diagnosis/Reason for Medication _____

Date _____ Signature _____ Relationship _____

Home Phone _____ Work Phone _____ Mobile Phone _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER FOR CONTROLLED SUBSTANCES

INSTRUCTIONS (Schedule & dose to be given at school) _____

Start: Date form received Other, as specified _____

Stop: End of school year Other, as specified _____

CONDITION for which medication is prescribed _____

PHYSICIAN'S SIGNATURE _____ Physician's Name _____

Date _____ Phone _____ Address _____

FOR SELF-ADMINISTRATION ONLY

Pursuant to DSISD School Board Policy and Section 22.052 of the Texas Education Code, the DSISD permits a student to possess and self-administer asthma or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian. (to be completed for students with asthma or severe allergic reaction, i.e. anaphylaxis, ONLY)

This student has been instructed on self-administration of this medication: ___supervision required ___supervision not required

Physician Signature _____ Date _____