Dripping Springs Independent School District
Walnut Springs Elementary
Charlene Cox RN CCRN- School Nurse
charlene.cox@dsisd.txed.net
P.O. Box 479, Dripping Springs, Texas 78620
(512) 858-3804 FAX (512) 858-3899

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, _____ for school personnel at Walnut Springs Elementary S___ the following medication according to the s___t the school will not be held responsible for any ill effects ___inistration of this medication.
Medication_____ _____ or per label
Drug Allergies_____
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

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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