CENTER INDEPENDENT SCHOOL DISTRICT HEALTH SERVICES

Request for Administration of Medication at School

Date school received form: _____

Student's name (print): _____

Date of Birth: _____ Grade: _____ Teacher/Classroom: _____

Name of medication: _____

Type of medication: _____Prescription _____Non-prescription (OTC)

Reason for medication: _____

Form of medication/treatment: (Check appropriate box)

_____Tablet/capsule _____ Injection _____ Other: _____

_____Liquid _____ Nebulizer

_____Inhalant _____ Spray/Cream or lotion

Instructions: (Schedule and dose to be given at school)

_____

Start Date: _____ Stop Date: _____

Restrictions and/or important side effects: _____ None anticipated _____Yes (see below)

If yes, describe: _____

Special storage instructions

_____None _____Refrigerate _____Other (please describe): _____

Physician information:

Name (print): _____

Address: _____ Phone: _____

Physician's signature: _____ Date: _____

To be completed by the parent or guardian

I give permission for _____ (student's name) to receive the above medication at school in accordance with District policy. [See FFAC]

Parent's or guardian's signature: _____ Date: _____

**This form was developed using resources from the American Academy of Pediatrics and Texas Department of State Health Services.