Lewisville ISD Health Services

Parent Request for Administration of Medication by School Personnel

picture

Name _____ DOB ____/____/____ ID#_____

School _____ Teacher/Grade _____

- Only medications that cannot be given outside the school hours will be administered.
- All medications must be in the original, current, properly labeled container with clear and legible instructions.
- Prescription labels must include: brand/generic name of drug, strength, manufacturer, pharmacy address, name of student and prescribing physician, date dispensed, expiration date of drug, and clear instructions for use, including specific times to be given.
- All medications to be administered at school must be FDA approved. Supplements, herbals, vitamins, homeopathic, and other non-regulated substances will not be given.

Condition for which medication is required: _____

Does your child take this medication at home? YES ☐ NO ☐ What Time: _____ Only as needed ☐

Instructions:_____

Medication	Dose in mg	Route	Time or Freq.	Indication for use	Start Date	Stop Date
					/ /	/ /
					/ /	/ /
					/ /	/ /

I request and authorize Lewisville ISD to administer the above medication(s) as prescribed. I understand that the school administrator may designate any qualified employee to administer this medication. I authorize the school registered nurse and the prescribing physician to confidentially discuss or clarify this medication order, and to discuss the student's response to the medication as required by law (Nurse Practice and Medical Practice Acts of Texas). If the consent for the nurse and the doctor to consult regarding this medication order is not granted or is revoked, it may not be possible for school personnel to administer the prescribed medications. I understand a reasonable attempt will be made to remind the student, but the student will be responsible to visit the health room for his/her medicine in most situations. This form is valid for one school year.

Parent Initials _____ Unused medications not picked up at the end of the school year or within five days of being discontinued will be disposed of properly.

Parent Initials _____ **ELEMENTARY STUDENTS** are not permitted to transport medications to and from school.

Parent Initials _____ **SECONDARY ONLY** - I GIVE permission for my child to transport medication to & from school.

Parent/Guardian Signature _____ Printed Name _____

Day Phone Number _____ Email _____ Date ___/____/____

Physician signature is required under the following conditions:

- Over-the-counter medications given more than 5 school days.
- Prescription label does not match the parent request or is missing the above required information.
- Medication samples or off-label prescription requests.

Physician Signature* _____ Print Name_____

*Physician must be licensed to practice in Texas. Temporary (2 months) orders for out of state US Physicians are acceptable for transferring students.

Date_____ Office Number _____ Fax Number _____

Med Expires: _____/_____ Weight (if needed): _____ kg Nurse's Notes: _____

Revised 6/2016