Pasadena Independent School District

PARENT REQUEST FOR ADMINISTRATION OF PRESCRIPTION MEDICINE IN SCHOOL

This form will only be valid for the current school year. A new form is required yearly. Please use a separate form for each medication. Medication to be administered for longer than ten (10) consecutive days will REQUIRE a physician's signature.

I request the nurse or designee to see that my child, _____ _____/____/___,
(Print Child's Name) (Date of Birth)
receives the prescribed medication for the duration of the current school year unless otherwise stated.

Is this the initial dose of a new medication that your child has NOT previously taken? ☐YES ☐NO

Patient Name: _____ DOB: _____

Diagnosis: _____ Medication (Trade name or generic): _____

Time(s) to be administered at school: _____

Dosage: _____

Route: _____

Other Information for School Nurse: _____

If medication is PRN (as needed), please specify: _____

_____
(Signs and symptoms)

Can dose be repeated? ☐Yes ☐No If yes, how many times in a school day? _____

_____/_____/_____ _____ _____
Date **Physician's Signature** **Physician's Printed Name**

_____ _____
Clinic / Physician's Phone # **Clinic / Physician's Fax #**

My signature below indicates that I request PISD staff or contracted outside agency staff to administer the medication specified above to my child, and I am giving permission for PISD staff or contracted outside agency staff to contact the physician for additional information, if needed.

Mi firma a continuación indica que solicito al personal de PISD o al personal externo contratado de la agencia que administre la medicación indicada para mi hijo(a), y le estoy dando permiso para el personal PISD o contratada fuera del personal de la agencia en contacto con el médico para información adicional, si es necesario.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Daytime Phone: _____ Email: _____

To be completed by School Nurse:

School Year: _____ - _____ *Student ID#:* _____ *HR Teacher:* _____

MEDICATION INVENTORY RECORD

To request medication administration at school, please note:

- A new form is needed for all changes in medication, dose, or time
- The medication should be brought to school by a parent/guardian or responsible adult
- The medication container should be labeled by the pharmacy with the student's name, prescriber's name, name of medication, dosage, route, conditions for storage, prescription date, and expiration date.
- Unless otherwise specified, medication order is valid for the entire school year
- Expired and discontinued medication not picked up by the last day of school will be destroyed.

Date	Amount Received (Count with Parent or Another Adult)	Signature of Person Bringing Medication	Signature of School Employee Receiving Medication

Medication Returned to:_____Date: _____

Parent/Guardian/Responsible Adult Signature

COMMENTS:

DATE	NOTES

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