DENISON INDEPENDENT SCHOOL DISTRICT

REQUEST FOR MEDICATION ADMINISTRATION

IMPORTANT MEDICATION PROCEDURES

- OTC medication needed for more than 10 days will REQUIRE a physician's signature.
- All medication MUST be in the original container and properly labeled.
- For prescription medication, please request pharmacist to dispense two labeled bottles of medication: one for home and one for school.
- Medications will be administered according to the label. Changes in medication (dosage/time) will require a new permission form and label.
- Medication may be administered by a non-health professional designate of the principal.
- We are unable to store any medication at the school during the summer (or once expired) and will dispose of all medicine left after the last day of school.

Student: ______________________ DOB:__________ Grade:________

Medication and Strength: ______________________ Dose: ______________

Take medication: ☐ by mouth ☐ inhalation ☐ topical (cream) ☐ injection ________ ☐ other______________

When: ☐ at the following time(s)__________- or - ☐ as needed every______hours ☐ May repeat________

To be given: ☐ Entire School Year - or - ☐ the following dates: ________ to __________

Condition for which medication is given: ______________________

Special considerations/side effects: ______________________

Other medications taken at home: ______________________

List any drug allergies: ______________________

Parent/Guardian: It is not feasible to schedule the above-medication at a time other than school hours. By my signature below, I request that this medication be given by a school employee. I understand that the School District, Board of Trustees, and District Employees shall not be held responsible for damages or injuries resulting from the administration of this medication. I authorize the nurse and the prescribing physician to confidentially discuss this medication order or the condition for which it is meant to treat.	
Signature:	Date:
Printed Name:	Phone:

Must be signed by a physician for any of these reasons:

☐ Over-the-counter to be given more than 10 days ☐ request of campus nurse

Physician: I request that the student receive this medication during the school day as instructed above.	
Signature:	Date:
Printed Name:	Phone: