Parent Request for Administration of Medication by School Personnel



Place Student Photo Here

CONFIDENTIAL

Date Entered in eSchool ______ Nurse Initials _____

Student Name								ID#	
Student's Date of Birth				1	Teacher			Grade	
As the Parent / Guardian of the above named child, I give my permission for him / her to be given the medication as described below by whomever the principal designates. I understand medication will be handled according to recommended Conroe ISD Policy and Procedure, TEA recommendations and FDA Guidelines.									
Printed Name of Parent/Guardian									
Signature Relationship to Student (Ex. Mom, Step Parent, Etc.)									
Daytime Phone Number(s)					Today's Date				
Name of Medication								Medication Strength	
Route of Administration: Dy mouth inhaled topical eye(s) ear(s) nasal injection (circle: IM SQ IV) rectal									
Dosage Reason for Taking									
Give Daily Time(s):					OR	Give PRN/As Frequency:	e PRN/As Needed quency:		
Medication Start Date				Medication	dication End Date			Medication Expiration Date	
Special Instructions									
Other Medication(s) Student is Taking									
CHANGES	Date Cha		nange in Dose, Amount, or Time					Parent Signature	
	Date		Change in Dose, Amount, or Time					Parent Signature	
MEDICATION CHECK-IN									
Date Received		Amount/	/Number	(Clinic Staff Signature			Parent/Guardian Signature	
Original									
REFILL(S)									
#1									
#2									
#3									
#4									
#5									
#6									
#7									
#8									
#9									

Med. Pick-Up Date______ By ______ Staff Initials ______ Count _____ Staff Initials _____