Houston Independent School District
Health and Medical Services

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

This form must be filled out completely to allow the School Nurse and /or other trained staff assigned by the Principal to administer medication to a student. A new medication form must be completed at the beginning of each school year for each prescription medication, and each time there is a change in the medication's administration instructions.

In accordance with district policy, only prescription medication will be administered.

- Prescription medication must be delivered to school in its original container.
- The container must be properly labeled by a pharmacist.

Student's Name _____ Sex_____

Date of Birth _____ / _____ / _____ Name of School _____

Medical Diagnosis: _____ ☐Infectious ☐Non-Infectious ☐Allergy

Medication Name: _____

Dose (amount to be given): _____

Frequency (how often): _____

Form of Medication (Route): _____

☐tablet ☐pill ☐capsule ☐liquid ☐inhalation ☐injection

☐ other (specify): _____

Possible side effects _____

Special requirements for administration / storage _____

Known food allergies YES NO If Yes, please explain _____

This is permission to give medication to my child named above as requested by the physician. I understand that I am giving consent for the school nurse to discuss any concerns regarding this medication with the healthcare provider whose signature appears on this document to monitor the healthcare needs of my child.

_____
Parent's Signature

_____
Telephone

_____
Date

_____
Physician's/Advanced Practice Nurse Signature

_____
Physician's/Advanced Practice Nurse Name (print or type)

_____
Date

_____
Facility Name

_____
Telephone