



# 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:

\_\_\_\_\_  
Facility Name

\_\_\_\_\_  
Physician's/Advanced Practice Nurse Signature

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

\_\_\_\_\_  
Telephone