PROSPER INDEPENDENT SCHOOL DISTRICT

PARENTS REQUEST FOR THE ADMINISTRATION OF MEDICATION TO A STUDENT

Name of Student_____ **Grade**_____

Type of Medication: Please check one---Prescription_____ **Over-the-Counter**_____

Medication Name_____**Dose**_____

Route (mouth, ear, etc)_____**Time to be given** _____

Condition for which medication is to be given_____

Phone Numbers- H_____**C**_____**W**_____

Start Date:_____ **End Date:**_____

Note: No more than one month's supply of medicine in a prescription-labeled bottle shall be brought to school at a time. Herbal or dietary supplements can be given only if accompanied with a doctor's order or prescription.

It is impossible to schedule the above, listed medication at a time other than school hours. I request that this medication be given by a school district employee. I understand that there may be circumstances when the RN may not be available and that this medication may be given by a school employee. I understand that the School District, Board of Trustees and the District employees shall not be held responsible for damages or injuries resulting from the administration of this medication. I have read the Medication Policy located at www.prosper-isd.net .

Should an over the counter medication be needed longer than 10 days, or 5 consecutive school days, I understand that a physician's statement is required. Medications will be given according to bottle directions, unless a physician statement indicates otherwise. All medications must be picked up on the last day of school or they will be discarded.

Parent/Guardian Signature_____ **Date**_____

Above medication brought to the clinic by an adult must be counted and signed by the school district employee and parent.

Date	PISD Counted	PISD Signature	Adult Counted	Adult Signature	***Date and signature of***
					parent or guardian
					picking up completed
					medication or year end.

Physician's Name (if prescription)_____**Phone Number**_____

Information concerning this medication and my child's health may be shared with/obtained from the above named physician.
Parent's signature_____**Date**_____