HEALTH SERVICES **SY 20_____-20_____**

Prosper Independent School District

Parent/Physician Request for Administration of Medication

Date of Request: ________________ **School:** ____________________ **Teacher/Grade:** ____________________

Student's Name: ____ **Birth date:** _____/______/__________

Medication: _______________________________________ **Medication Expiration Date** (MM/YY): ____________

Amount to be given: _______________ **Time(s) to be Administered:** _________________________________

Route of administration: ☐ by mouth ☐ inhaled ☐ topical ☐ eye ☐ ear ☐ nasal ☐ injection ☐ rectal ☐ GT/JT

Dates to be Administered: ☐ School Year ☐ Other date range: ____

Condition for which medication is required: ____

Is this medication prescribed for additional doses outside of school hours? ☐ YES ☐ NO

If yes, please specify (if not included on prescription label):____

Has your child taken this before? ☐ YES ☐ NO **Known Medication Allergies:** ______________________

Special Instructions or known side effects of medication for your child: _______________________________

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The above listed medication must be given during school hours. My signature below indicates that I request that PISD staff administer this medication to my child. I am giving permission for PISD staff to contact the prescribing provider and pharmacy for additional information regarding this medication, if needed. I understand that for prescription medications, only a 30-day supply will be accepted at a time. I agree to pick up any unused, discontinued, or expired medication and understand that medication not picked up will be disposed of at the end or the school year or within two weeks after the medication expires or is discontinued, whichever is earlier.

Parent/Guardian Signature: ____________________________________**Phone:** (______)_________-_____________

Medications with a printed pharmacy label for the student do NOT require the physician's signature below. Additionally, parent-provided nonprescription medication from the district-approved list may be given up to 10 times during a school year (and no more than 5 consecutive school days) without a physician signature. A physician signature (or written physician order) IS required however, for all other nonprescription medications needing to be kept at school for more than 10 school days from the date of the original request, for nonprescription medication requested at a dosage or frequency different than indicated on the package directions, or for medications containing aspirin.

Physician's Name: ____ **Phone:** (______)_________-_____________

Physician's Signature: ____

FOR OFFICE USE ONLY ----------------------------- ☐ Initial RN Review _______ ☐ Skyward MAR ☐ Teacher Notified

Prescription Medication Count:

Date	# Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials

Date	Comments	Date	RN Review