SY ____-____

HEALTH SERVICES
Prosper Independent School District

Parent/Physician Request for Administration of Medication by School Personnel

Date of Request: _____ **School:** _____ **Teacher/Grade:** _____

Student's Name: _____ **Birth date:** _____/_____/_____

Medication: _____ **Exp. Date**_____ **Dosage:** _____

Route of administration: ☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ injection (circle: IM SQ IV) ☐ rectal ☐ GT/JT

Time to be Administered: _____ **Dates to be Administered:** _____

Condition for which medication is required: _____

Has your child ever taken this medication before? YES NO

Medication Allergies: ☐ No Known Medication Allergies ☐ Allergic to: _____

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

_____

Note: Herbal substances and dietary supplements are not tested or regulated by the US Food and Drug Administration for safety or effectiveness. Lack of safety information limits their appropriate use at school. These medications will not be administered unless it has been determined educationally necessary as part of a student's individualized education plan or Section 504 plan and accompanied by a physician's prescription.

It is impossible to schedule the above-mentioned medication at a time other than school hours. My signature below indicates that I request that PISD staff administer the medication specified above to my child, and I am giving permission for PISD staff to contact the physician 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. Unused, discontinued, or expired medication must be picked up by the parent/guardian. I understand that medications not picked up will be disposed of at the end or the school year or within two weeks after discontinued.

Parent/Guardian Signature: _____

Parent's Primary Phone: (_____)_____-_____ **Alternate Phone:** (_____)_____-_____

Physician's Name: _____ **Phone:** (_____)_____-_____

**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 is required for all other nonprescription medications needing to be kept at school for more than 10 school days from the date of the original request. Medications with a printed pharmacy label for the student do NOT require the physician's signature below.*

***Physician's Signature:** _____

FOR OFFICE USE ONLY ☐ Entered in Skyward ☐ Teacher Notified ___/___

Prescription Medication Count:

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

Date	Comments	Date	RN Review

Medication returned to Parent: _____ Date _____
Parent Signature