

**Parent Request for Administration of Medication by School Personnel**

*This request is intended only for medication that cannot be administered at home. Medication should be delivered to the campus clinic or office by the student's parent/guardian in the original container, not loose or in a baggie.*

*Permission is valid for the current school year and medication should be picked up at the end of each school year. Medication is not kept on campus during summer unless the student attends summer school. Unclaimed medication is destroyed at the end of each school year.*

**Please print using black or blue ink:**

Campus: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_ / \_\_\_\_\_

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescribed by: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Prescription #: \_\_\_\_\_

Student Drug Allergies: \_\_\_\_\_

Medication: \_\_\_\_\_ Strength: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Time: \_\_\_\_\_

Route:  Oral  Inhaled  Topical  Eye  Ear  Nasal  Rectal

Injection: Type \_\_\_\_\_  Enteral Feeding Tube Type: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Is this the first dose of a new medication for your child?  Yes  No

Side effects for student, special instructions, other pertinent information: \_\_\_\_\_

**Student may be given the prescribed morning dose of medication, if forgotten at home, with telephone permission from parent.**

*I confirm that it is not possible to administer this medication at home and hereby request that the medication listed above be administered by a Mesquite ISD employee.*

*I understand that the School District, its Board of Trustees, and its employees are immune from civil liability from damages or injuries resulting from administration of this medication (Texas Education Code 22.052).*

*I authorize the district registered nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per State law (Nurse Practice Act & Medical Practice Acts of Texas).*

Parent/Guardian Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime telephone number: \_\_\_\_\_

**Sample medication, over-the-counter medication, or instructions differing from the medication prescription label require a separate physician's order or physician's signature below.**

\_\_\_\_\_  
Physician's Signature & Printed Name

\_\_\_\_\_  
Telephone Number

**FOR OFFICE USE ONLY**

Date	# Pills	Counter Signature	Witness Signature	Date	# Pills	Counter Signature	Witness Signature