

FRANKSTON INDEPENDENT SCHOOL DISTRICT
PO BOX 428, 100 PERRY STREET
FRANKSTON, TX 75763

**PHYSICIAN/PARENT REQUEST FOR ADMINISTRATION OF MEDICINE OR
SPECIAL PROCEDURE BY SCHOOL PERSONNEL**

Special health care procedures and medication may be administered by school personnel as follows:

1. When such medication/procedure cannot be accomplished except during school hours
2. On receipt of this completed form along with the prescription medication and/or the special equipment
3. prescribed by a physician/dentist and in the **original container** with the pharmacy label- please request the pharmacist to dispense two labeled bottles of medication- one for home and one for school
4. Inhalers are permitted to remain with students beginning in 7th grade, provided the parent sign the permit form and verify students can effectively use their inhalers. After med use, student must see the nurse or inform the coach if in athletics for evaluation of effectiveness.

Student Name _____ Date of Birth _____

School year _____ Grade _____ Teacher _____

Condition for which medication/procedure is prescribed _____

Prescribed medication/procedure _____

Dosage and method of administration _____

Time to administer medication/procedure at school _____

Precautions or possible unfavorable reactions to observe for _____

Date of request _____ Date of termination _____

Physician name and signature _____

*** (Physician signature only required for treatments and or procedures) *****

Physician address _____ Phone number _____

We (I), the parent/guardian of _____ request the above medication/procedure be administered by the school nurse or the designee of the principal to our (my) child. We (I) give my permission for the school nurse to contact the above named physician to discuss the medication/procedure prescribed. We (I) also give my permission for information regarding this medication/treatment to be shared by the school nurse with school personnel on a need-to-know basis.

I understand parents are to pick-up all medications by 3:00 on the last day of school. All medications remaining after that time will be discarded.

_____/_____/_____/_____
Parent/Guardian Name Relationship Home # Work #