Houston County School District
Medication Form (HRS 29)

If this form is properly completed and returned to the school, the Houston County School District (HCSD) may assist students in taking their medication during school hours. FAX to (478) 328-1407

- **All medication (no narcotics) must be presented to the school office by a parent or guardian in a prescription labeled bottle, which will include the student's name, date, instructions for administering, name of the drug, and name of the issuing physician.**
- **A medication administration form (HRS 29) is required to be filled out by the physician and parent in cases of long-term medication (more than 10 doses).**
- **It is the responsibility of the parent/guardian to inform the school of any changes.**
- **A new HRS 29 must be provided for each school year and with each new medication or dose.**
- **Unused medication will be disposed of if not picked up within one week of discontinuation or the end of the school year.**

Name of student: _____Date of birth: _____

Allergies: _____School: _____

As a parent/guardian of the above-named student, I do hereby request the HCSD to give medication to the above-named student. I understand that the school district is not legally obligated to administer medication except to a student whose disability requires the administration of medication to benefit from his/her educational program and who is afforded accommodations under applicable federal law. I understand that school personnel will administer medication in accordance with the policy and procedures of the HCSD. I consent to the release of medication information by and to my student's physician and/or pharmacist as needed.

_____ _____ _____

Signature of Parent/Guardian Date Phone number

----------BELOW TO BE COMPLETED BY PROVIDER----------

Medication: _____ Student's Diagnosis: _____

Scope: This medication must be administered during the student's school day. ICD-10 Code: _____

Dose: _____Time/Frequency: _____ Route: _____

Provider's Signature: _____ Date: _____

Print Provider's Name: _____Provider's Phone: _____

NPI: _____

School Nurse Signature: _____ Date: _____