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 SCHOOL YEAR ______________

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 provided by the parent/guardian.
3. Prescribed by a physician/dentist and in the **original container with the pharmacy label** (no Ziploc bags, dosing syringe. Please request the pharmacist to dispense two labeled bottles of medication. One for home and one for school).
4. Asthma and anaphylaxis medications may be permitted to remain with students beginning in 6th grade after this form has been returned with parent and physician written permission (***see section below)*** as well as FISD nurse will request student to demonstrate skill level necessary for self-administration.
5. The prescription label on prescription medications will serve as physician signature. Physician signature is required for over- the-counter medications if given more than 5 times in a semester or for off label medication use.

Student Name ____ Date of Birth ___________________Grade_________

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 ______________________________

We (I), the parent/guardian of above-named student request the above medication/procedure be administered by the school nurse's office 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.
We (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 #

_____________________________ / ______________________ / _________________________ / _________________________

Signature of Person Receiving | Date | Amount | Returned # & Date

*****PHYSICIAN/HEALTHCARE PROVIDER***** (only complete if needed)

_____ (Physician initials) *I have instructed this student and give my permission for the self-carry of their emergency asthma and/or anaphylactic allergy medication. (Check applicable)* □ inhaler (MDI) □ epinephrine auto-injector.

_____ (Physician initials) *For severe breathing difficulty, emergency asthma medication (specify): ___________________ inhaled dose: □ 2 puffs □ 4 puffs □ ampule may be repeated _____times ______minutes apart.*

____ (Physician initials) *I have determined the off-label medication is necessary at school and further state that this medication has been clinically determined to be safe and effective based on this student's health needs.*

I request and authorize the above medication(s), dosage, and frequency.

____ ____

Prescribing physician printed name | Date

____ ____

Prescribing physician signature | Office phone number