**NATALIA INDEPENDENT SCHOOL DISTRICT**

**HEALTH SERVICES**

**PHYSICIAN/PARENT REQUEST FOR ADMINISTRATION OF**

**MEDICATION BY SCHOOL PERSONNEL**

Medications may be administered at school by the nurse or authorized trained school personnel when such treatment is necessary for school attendance. If possible, medication should be given outside of school hours. This form must be completed and returned before administration of medication will occur. A new medication form is required each school year.

The medication must be brought to the school in the original container appropriately labeled by the pharmacy. Parent/Guardian should request that the pharmacist dispense two (2) bottles of medication, one for home and one for school.

It is recommended that this form be taken at the time of the appointment for the physician to complete. \****Specific forms must be completed by the healthcare provider for asthma, seizures, life-threatening allergies, and diabetes.***

Please contact the school nurse for more information or any questions.

**Student**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **School ID**\_\_\_\_\_\_\_\_\_\_\_\_ **Grade: \_\_\_\_\_\_**

**FOR MIGRAINES/HEADACHES- NOT FOR FEVER**

| **Medication Name/ Strength** | **Dose** | **Route** | **Time/Frequency** | **Diagnosis/Condition** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

| **Special Instructions:** |
| --- |
| **Precautions/Untoward Reactions/Interventions/Emergency Measures:** |

**Medication to be administered until the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or end of school year.**

**Physician’s Signature** **/Printed name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian:**

We, (I), the undersigned, the parent/guardian of (printed student name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, request the above medication be administered to my child while at school. I give permission for the school nurse to exchange information with the prescribing primary care provider concerning the administration of this medication.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature Relationship Date**

**Telephone #: Home/Cell** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Extension** \_\_\_\_\_\_\_\_\_\_\_\_\_\_