DOWNLOAD THIS FORM BEFORE FILLING IT OUT OR INFORMATION WILL BE LOST

Parent Request for Administration of Medication by School Personnel

CONROE INDEPENDENT SCHOOL DISTRICT
Health Services

Place Student Photo Here

CONFIDENTIAL

SCHOOL YEAR _____

Parent/Guardian email _____

Parent/Guardian email _____

Date Entered in eSchool _____ Nurse Initials _____

Student Name *(first / last)* _____ **ID#** _____

Student's Date of Birth _____ **Teacher** _____ **Grade** _____

As the Parent / Guardian of the above named child, I give my permission for him / her to be given the medication as described below by whomever the principal designates. I understand medication will be handled according to recommended Conroe ISD Policy and Procedure, TEA recommendations and FDA Guidelines.

Printed Name of Parent/Guardian _____

Signature _____ **Relationship to Student** (Ex. Mom, Step Parent, Etc.) _____

Daytime Phone Number(s) _____ **Today's Date** _____

Name of Medication			**Medication Strength**
Route of Administration: ☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ injection: (☐ IM ☐ SQ ☐ IV) ☐ rectal			
Dosage	**Reason for Taking**		
Give Daily **Time(s):**	**OR**	**Give PRN/As Needed** **Frequency:**	
Medication Start Date	**Medication End Date**		***Medication Expiration Date***
Special Instructions			
Other Medication(s) Student is Taking			

IF THERE IS A CHANGE IN DOSAGE, AMOUNT, OR TIME, FILL OUT A NEW MEDICATION PERMISSION FORM.

MEDICATION CHECK-IN			**PRINT FORM AND MANUALLY SIGN**
Date Received	**Amount/Number**	**Clinic Staff Signature**	**Parent/Guardian Signature**
Original			
REFILL(S)			
#1			
#2			
#3			
#4			
#5			
#6			
#7			

Physician Name _____ Physician Phone Number _____

Physician Signature _____ Date _____

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Med. Pick-Up Date_____ **By** _____ **Relationship** _____ **Count** _____ **Staff Initials** _____