Kaufman Independent School District
PREPARATION ★ PURPOSE ★ PRIDE

KISD HEALTH SERVICES

Parent Request for Administration of Prescription Medication given for LESS than 10 consecutive days

Medication MUST be in Original Container

Date of Request: _____School:_____Grade/Teacher:___/_____

Student's Name: _____ Birth date: _____/_____/_____

School Nurse Phone: _____ School Fax_____

Prescription Medication: _____ Exp. Date_____

Prescription medications must come in the original container labeled with:

• Child's name_____

• Name of medicine_____

• Time medicine is to be given_____

• Dosage_____

• Date medicine is to be stopped_____

• Licensed health care provider's name_____

• Pharmacy name & phone number_____

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with KISD nursing staff or school staff delegated to administer medication.

Physician Name: _____Physician Phone/Fax: _____

_____ Cell Number: _____

Parent/Legal Guardian Name

Work Number: _____ ext._____

Parent/Legal Guardian Signature_____

Date: _____

Revised 9-4-2018