Kaufman Independent School District
PREPARATION ★ PURPOSE ★ PRIDE

KISD Health Services

Parent Request for Administration of Non-prescription Medication by School Personnel

Date of Request:_____School:__MES___ Grade/Teacher: ___/_____

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

Medication:_____ Exp. Date_____Dosage:_____

School Fax Number:_____School Nurse Phone Number: _____

Medication MUST be in Original Container

Method of administration: ( ) by mouth ( ) inhaled ( ) topical ( ) eye(s) ( ) ear(s) ( ) nasal ( ) gastric tube

Time to be Administered:_____ Dates to be Administered:_____

Condition for which medication is required:_____

Has your child ever taken this medication before? ( ) YES ( ) NO

Medication Allergies: ( ) No **KNOWN** Medication Allergies ( ) **Allergic to**: _____

Special Instructions/Precautions/Side Effects of medication on your child:

_____

Physician's Name:_____

Physician's Signature required if non prescription medication needed more than 10 consecutive days or 10 consecutive doses: Physician Signature:_____

Physician's Phone #:_____Physician's Fax #:_____

My signature below indicates that I request that KISD staff administer the medication specified above to my child, and I am giving permission for KISD staff to contact the physician for additional information, if needed. I release the school from any liability due to allergic medication reaction.

Parent/Guardian Signature:_____Email:_____

Parent's Daytime Phone:_____x_____ Cell Phone:_____