

**Midlothian ISD
Health Services
Prescription Medication Administration**

PARENT'S REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION TO A STUDENT

All prescription medication MUST be in the original container with a pharmacy prescription label. No more than **one month's** supply of medication, in a prescription labeled bottle, shall be brought to the clinic at one time. .

Note: We are unable to store any medications at the school during the summer and will dispose of all medicine left after the last day of school.

Name of Student: _____ Date of Request: _____

Birth Date: _____ Grade: _____

School: _____ Teacher: _____

Name of Medication: _____ Expiration date: _____

Condition for which medication is to be given: _____

Amount to be given: _____ Time to be given: _____

Special instructions: _____

Date medicine is to be discontinued: _____

I consent to the release of the medical information contained on this form to school officials who have a legitimate educational interest in the information, according to MISD Board Policy and the Family Education Right and Privacy Act. I give permission for the release of confidential information regarding my child's specific health problems to third parties, other than school officials, as required to facilitate medical care and/or treatment of my child. I authorize the nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

Signature of Parent or Guardian

Daytime Phone Number

Date

Printed name of Physician

Phone Number/Fax Number

Signature of Physician

Date

MISD will not discriminate in its educational programs, activities, or employment practices, based on race, ethnicity, gender, disability, religion, or any other legally protected classification.

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December/2017