San Angelo Independent School District
Health Services
Student Medication Record
(OTC and Short Term Prescription Medications)

Count _____

Signature for Initial ID:
_____
_____
_____

Only one medication per form

Date	Time/# given	Initial	Date	Time/# given	Initial	Date	Time/# given	Initial

Request to Supervise Medicine at School

Student Name: _____Teacher:_____Grade:_____

Medication: _____ Dose: _____

Time: _____ Dates to be administered: _____

Reason for administering medication: _____

_____ _____
Prescription Number Pharmacy Name

I give permission for the school nurse/staff to administer this medication to my child as directed on the label.
***If this medication is to be given on a regular basis (three consecutive days or more), a **physician's order** will be required.

_____ _____
Parent/Guardian Signature *Date*

At the end of the school year (please check one):

( ) Destroy remaining medication.
( ) Parent will pick up remaining medication. _____
Signature Date Picked Up

All unclaimed medication will be discarded on the last day of school. (Rev. 05/19)