MAGNOLIA INDEPENDENT SCHOOL DISTRICT
P.O. Box 88
Magnolia, TX 77353
P 281.356.3571

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Name of Student _____ DOB _____ Grade _____

Address _____

To be completed by the physician or authorized prescriber.

Medication _____

Dosage _____

Route of administration:

Tablet/Capsule Liquid Nebulizer Injection Inhaler Other _____

Time medication is to be given at school _____

(If to be given at lunch, please be aware that the student's lunch may not be at noon. Please state "lunch" so that the time frame may be adjusted according to the student's lunch schedule.)

Condition for which the medication is to be given: _____

Special instructions: _____

Special storage requirements: None Refrigerate Other _____

Permission for a student using an inhaler to carry inhaler with him/her: ☐ Yes ☐ No

This student has been taught the proper use of an inhaler and is both capable and responsible for self-administering this medication.

Physician's Name (please print) _____

Physician's Address _____

Physician's Telephone Number _____ Fax Number _____

Alternate Physician _____ Telephone Number _____

Physician's Signature _____ Date _____

To be completed by the parent/guardian of the student receiving medication at school and/or carrying self-administered asthma medication.

I release the school district and its employees and agents from liability for an injury rising from (name of child) _____ self-administering of prescription asthma medicine while on school property or at a school related event or activity. I agree to indemnify the school district and its employees and agents from any claim arising from (name of child) _____ self-administration of prescription asthma medicine while on school property or at a school related event or activity.

To be completed and signed by parents/guardians.

I give permission for (name of child) _____ to receive the above medication at school according to standard school policy. The nurse has my permission to inform my child's teacher/s about this medication. The nurse has my permission to speak with my child's doctor as needed.

Date _____ Signature _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Parents/guardians are required to bring all medication to school in its original container with the correct labeling. All medication must be picked up by the parent/guardian from the school clinic when school is out for summer or when the medication is discontinued without using all of the medication. The school nurse will dispose of medication left in the clinic at the end of the school year.