Bullard Independent School District

Parent/Physician Request for
Administration of Medication by School Personnel

Medication may be administered by school personnel as follow

1. When such treatment cannot be accomplished except during school hours.
2. On receipt of this completed form along with the medication.
3. Prescribed by a physician/dentist and in the original container with the pharmacy label---please request the pharmacist to dispense two labeled bottles of medication---one for home and one for school.

Date of Request:_____ Teacher: _____ Grade: _____

Student's Name: _____ DOB:_____

Known drug allergies:_____

Condition for which medication is required:_____

Medication:_____ Exp.Date: _____ Dosage:_____

Time to be Administered: _____ If PRN, for what symptoms:_____

Duration (dates) of administration: From: _____ to _____ (limit 1 school year)

Is this a controlled drug ____ Yes ____ No

Is this the initial dose of a new medication that has not been administered at home? ____ Yes ____ No

Special Instructions/Precautions/Side Effects of Medication:_____

Physician's Name: _____ Phone: _____

*Physician's Signature:_____

**Physician's signature is required to administer over-the counter medications.*
The prescription label on a prescription medication will serve as the physician signature.

My signature below indicates that I request that BISD staff administer the medication specified above to my child, and I am giving permission for BISD staff to contact the physician for additional information, if needed. I also give my permission for information regarding this medication to be shared with school personnel on a need-to-know basis.

I understand that parents are to pick-up all medications by 3:00 on the last day of classes and that all medications remaining after that time will be discarded.

Parent/Guardian Signature:_____ Phone: _____

Only a 30-day supply of medication will be accepted at a time

FOR OFFICE USE ONLY

DATE	# PILLS	COUNTER SIGNATURE	WITNESS SIGNATURE		DATE	# PILLS	COUNTER SIGNATURE	WITNESS SIGNATURE

One form per medication