HURST-EULESS-BEDFORD I.S.D.
PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICINE
SECONDARY SCHOOLS

Name of Student: _____ DOB: _____/_____/_____

School: _____ School's Phone: _____ School's Fax #_____

1. Condition for which prescribed treatment is required:

2. Precautions, unfavorable reactions, limitations after administration of medicine or procedure:

3.*Student may carry inhaler or epinephrine device with him/her at all times unless otherwise specified by a physician.

Starting Date	**Name of Medication(s)**	**Strength** **(i.e., 12mg)**	**Dosage** **(i.e., 2tabs, 1 tsp.)**	**Route** **(i.e. oral, topical)**	**Time To Be Given**

Date of request: _____ Date of Termination: _____

_____ _____

Physician's Name (Printed) **Physician's Signature**

_____ _____/_____

Physician's Address Physician's Phone # Fax #

PARENT/GUARDIAN:

We, (I), _____

Name of Parent/Legal Guardian (Please Print)

Consent for the principal or designee to administer the above medication or procedure to (my) child during school hours as specified by my physician.

I agree to furnish any supplies or necessary equipment required. I understand that the school must have the following information prior to administering medication to my child. All medication brought to school shall be in the original labeled prescription container by a responsible adult. For the protection of the student, over-the-counter medicine also be in the original container.

*It is advisable to keep an inhaler in the nurse's office for emergencies or when a student may forget his/her inhaler. Extra inhaler will be brought to the nurse's office. _____Yes _____No

Parental Consent: I consent to and authorize the health care provider to disclose health information to the school, and for the school to disclose the above information to those within the school district who have a need to know for legitimate educational purposes. First dose of any medication must be given at home in case of untoward reaction.

Medication Pick up: Parent is responsible for picking up all student medications. Parent will need to provide this authorization and medication if needed for any summer programs. Please keep a copy of this form for your records.

_____ _____

Parent/Guardian Signature Relationship to Student

Home Phone # _____ Work Phone #_____ Cell Phone #_____

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