HURST-EULESS-BEDFORD I.S.D.
PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICINE
ELEMENTARY SCHOOL

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/epi-pen/diabetes management supplies and equipment with him/her at all times upon physician and parent approval, **if the student has demonstrated competence in self-administration**.

Starting Date	Name of Medication(s)	Strength (i.e.,12mg)	Dosage (i.e. 2 tabs, 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. This includes both prescription and over the counter medication.
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 must also be in the original container.
***It is advisable to keep an inhaler/epi-pen/diabetes management equipment in the nurse's office for emergencies or when a student may forget his/her inhaler.**
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 #**_____________________________

Updated 8 FEB 2022

Form #729-15