Calallen I.S.D.
Health Services Department
Physician/Parent Request for Administration of Medication

Effective for the _____ school year

Student's name _____D.O.B. _____

Medication (generic name if used) _____

Route _____ Dosage amount _____ Time to administered at school _____

Condition for which medication is to be given _____

Special Instructions/Precautions/Side Effects:_____

***Inhalant, Eye, Ear or Topical Prescriptions**

This student is both capable and responsible for self-administration of this medication:
____No _____ Yes-supervised _____ Yes-unsupervised
This student may carry this medication _____ Yes _____No

Physician Signature _____ Print name _____

Phone _____ Fax_____ Date of request _____

I understand that a person who is not medically licensed may administer the medication and/or treatment. I understand that: (1) that in accordance with Texas Education Code 21.905 medication is defined as: substances used to prevent, diagnose, cure, or relieve signs and symptoms of disease; (2) there is no liability on the part of Calallen I.S.D. or it's employees for administration of medicine requested by the parent/guardian and for adverse reactions or side effects to the medication; (3) I agree to be responsible for maintaining an adequate supply of medications at the school to meet the child's needs; (4) this medication will be brought to school only by a parent/guardian; (5) that my child will not be in possession of any medication at any time unless they have written permission from a physician stating they have a condition that requires immediate treatment; (6) this medication will be "properly labeled" as defined in the Calallen I.S.D. Nursing policy manual; (7) this medication will be destroyed if it is not picked up; (8) in accordance with the Nurse Practice Act, Texas Code, Section 217.11, The school nurse has the responsibility and authority to refuse to administer medications that in the nurse's judgment are not in the best interest of the student. I hereby authorize the exchange of medical information regarding my child's medication/treatment plan between the physician and Calallen I.S.D. Health Services Department.

Parent/Guardian Signature _____ Date _____

The attending physician must renew medication orders and this release signed by the parent/guardian annually. The most current physician's order, label on medication, and student medication log all must have matching information. Consequently, if all three do not match your child will **not** receive the medication at school.

FOR OFFICE USE ONLY
MEDICATION AMOUNT RECEIVED

Date	Count	Parent/Guardian Signature	Initials	Date	Count	Parent/Guardian Signature	Initials

MEDICATION PICKED UP BY: PARENT/GUARDIAN_____ DATE:_____

Revised: 04/18