LAKE TRAVIS
INDEPENDENT SCHOOL DISTRICT

# Request for Medication Administration

Student: _____ DOB _____ Grade: _____ Campus: _____

Medication: _____ Dose: _____

Take medication: □ by mouth □ via inhaler □ topical (cream) □ injection □ other _____

Condition for which medication is given: _____

To be given: □ Entire School Year - or - □ The following dates: ___ /___ /____ to: ___ /___ /____

When: □ At the following time(s): _____ - or - □ As needed every _____ hours Special

considerations/side effects: _____

For Daily Medications: _____ Yes, please send on field trips
_____ No, please do not send on field trips

Other medications taken at home: _____
List any food or drug allergies: _____

**Must be signed by a physician for any of these reasons:**

□ prescription given more than 10 school days (daily medication)
□ any over-the-counter medication

***Parent/Guardian:*** I give permission for district personnel to administer medication to my child in accordance with Texas Education Agency and District policies. I also acknowledge that it is the parent/guardian responsibility to maintain medication supply. Unclaimed medication will be destroyed at the end of the school year.

| | |
|---|---|
| Signature: | Date: |
| Printed Name: | Phone: |

***Physician:*** I request that the student receive this medication during the school day as instructed above.

| | |
|---|---|
| Signature: | Date: |
| Printed Name: | Phone: |

***School:*** Medication was received by:

| | | |
|---|---|---|
| Signature: | Date: | Quantity Received: |
| Printed Name: | Phone Ext.: | Expiration Date: |