Received Form On _____
Received By _____

Updated 4/2024

Parent/Physician Request for Administration of Medication by School Personnel

School: _____ Teacher/Grade: _____

Student's Name: _____

Student's ID#: _____ Birth Date: _____ / _____ / _____

Medication: _____ Dosage: _____ Exp. Date: _____

Route of administration: □ by mouth □ inhaled □ topical □ eye(s) □ ear(s) □ nasal □ injection (circle: IM SQ IV) □ rectal □ GT/JT

Time to be Administered: _____

Dates to be Administered: _____ to Date _____ OR □ Entire school year

Condition for which medication is required: _____

Has your child ever taken this medication before? YES NO *All first doses of medication must be administered at home.*

Medication Allergies: □ No Known Medication Allergies □ Allergic to: _____

Special instructions or known side effects of medication: _____

_____

Please indicate how you would like the medication to be returned home:
□ Send home in my child's backpack*
**Controlled substances (such as Ritalin, amphetamine salts, etc.) and Epi-pens must be transported by a parent/guardian and will not be released to students.*
□ Parent/Guardian will pick up med from clinic
□ Do not return med, please discard any remaining doses
*Any medication not picked-up by the last day of school will be disposed.

My signature below indicates the following 1) I request that PfISD staff administer the medication specified above to my child, and I am giving permission for PfISD staff to contact the physician for additional information, if needed, and 2) I have read the online medication policy located on the PfISD Health Services page and agree to abide by all policies.

Parent/Guardian Signature: _____ **Date:** _____
Parent's Primary Phone: (____) _____ - _____ **Email**: _____
Physician's Name: _____ **Phone**: (_____) _____ - _____

**A physician's signature is required to administer medications.*

***Physician's Signature**: _____ **Date:** _____

Medication returned to: Parent / Student_____Date _____
Parent/Student Signature

Off-line documentation

Date	Time	Reason	Nurse Signature

FOR OFFICE USE ONLY!

☐ Entered in Skyward

☐ Teacher Notified___/___

Medication Count When Receiving From Parent:

Date	# Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials

Weekly Prescription Medication Count:

August	Count	Signature	Witness Signature
Week 1			
Week 2			
Week 3			
Week 4			
Week 5			

September	Count	Signature	Witness Signature
Week 1			
Week 2			
Week 3			
Week 4			
Week 5			

October	Count	Signature	Witness Signature
Week 1			
Week 2			
Week 3			
Week 4			
Week 5			

November	Count	Signature	Witness Signature
Week 1			
Week 2			
Week 3			
Week 4			
Week 5			

December	Count	Signature	Witness Signature
Week 1			
Week 2			
Week 3			
Week 4			
Week 5			

January	Count	Signature	Witness Signature
Week 1			
Week 2			
Week 3			
Week 4			
Week 5			

February	Count	Signature	Witness Signature
Week 1			
Week 2			
Week 3			
Week 4			
Week 5			

March	Count	Signature	Witness Signature
Week 1			
Week 2			
Week 3			
Week 4			
Week 5			

April	Count	Signature	Witness Signature
Week 1			
Week 2			
Week 3			
Week 4			
Week 5			

May	Count	Signature	Witness Signature
Week 1			
Week 2			
Week 3			
Week 4			
Week 5			