CELINA INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

# Medication Administration Form

Date of Request: _____School: _____Teacher/Grade: _____

Student's Name:_____Birth date:____/_____/_____

Medication:_____Exp Date:_____Dosage:_____

Route of administration:

- ☐ By mouth
- ☐ Inhaled
- ☐ Topical
- ☐ Eye
- ☐ Ear
- ☐ Nasal
- ☐ Injection
- ☐ Rectal
- ☐ Gastrostomy

Time to be administered:_____Dates to be administered:_____

Condition for which medication is required? _____ Has your child ever taken this medication before? YES/NO

Medication Allergies: _____

Special instructions or known side effects of medication for your child: _____

It is impossible to schedule the above-mentioned medication at a time other than school hours. My signature below indicates that I request that CISD staff administer the medication specified above to my child. I am permitting CISD staff to contact the physician for additional information regarding this medication if needed. I understand that for prescription medications, only a 30-day supply will be accepted at this time. Unused, discontinued, or expired medication must be picked up by the parent/guardian. I understand that medications not picked up will be disposed of at the end of the school year or within two weeks after discontinuation.

**Parent-provided nonprescription medication may be given up to 10 times per year (and no more than 5 consecutive school days) without a physician's signature. A physician's signature is required for all other nonprescription medications that need to be kept at school for more than 10 school days from the date of the original request. Medicines with a printed pharmacy label for the student DO NOT require the physician's signature below.*

Parent/Guardian signature:_____

Physician name:_____Phone:_____

*Physician's signature: _____

CONTROLLED MEDICATION COUNT

| | Date (DO/PU?) | Count | CISD Witness | Witness #2 | | Date (DO/PU?) | Count | CISD Witness | Witness #2 |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | 6 | | | | |
| 2 | | | | | 7 | | | | |
| 3 | | | | | 8 | | | | |
| 4 | | | | | 9 | | | | |
| 5 | | | | | 10 | | | | |

Medication Picked up by parent (signature): _____ Date: _____

Medication disposed of (date):_____ Count Complete? YES/NO

RN Signature: _____

Witness Signature:_____

---

MAR *(The below MAR should be used during Skyward downtime or substitute coverage only.)*

| | Date | Time | Amount | Initials | | Date | Time | Amount | Initials |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | 12 | | | | |
| 2 | | | | | 13 | | | | |
| 3 | | | | | 14 | | | | |
| 4 | | | | | 15 | | | | |
| 5 | | | | | 16 | | | | |
| 6 | | | | | 17 | | | | |
| 7 | | | | | 18 | | | | |
| 8 | | | | | 19 | | | | |
| 9 | | | | | 20 | | | | |
| 10 | | | | | 21 | | | | |
| 11 | | | | | 22 | | | | |