KELLER INDEPENDENT SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's name: _____DOB: _____Grade: _____ Teacher: _____

Only medications that are required to enable a student to stay in school may be administered at school.

Medication will be administered at school under the following conditions:

1. MEDICATION MUST BE IN ORIGINAL PROPERLY LABELED CONTAINER, dated for the current school year and brought to school by an adult. MEDICATION SENT IN BAGGIES OR UNLABELED CONTAINERS WILL NOT BE GIVEN.

2. Prescription medications will only be administered with a specific written request signed by at least one parent/guardian. Physicians must be licensed to practice medicine in the State of Texas. A current prescription label will serve as the physician's signature.

3. FDA APPROVED OVER THE COUNTER MEDICINE REQUIRES PARENT/GUARDIAN WRITTEN PERMISSION AND A PHYSICIAN'S SIGNATURE. PHYSICIANS MUST BE LICENSED TO PRACTICE MEDICINE IN THE STATE OF TEXAS.

4. A trained unlicensed employee may administer the medication.

5. All medications must be kept in the clinic, except for students whose physician and parent furnishes the school with a written permit to carry an inhaler or epi-pen on their person.

6. Medication must be picked up by parent/guardian by the end of the school year. Otherwise, it will be destroyed.

7. The District can assume no responsibility for loss or negligent behavior when the student carries his/her conventional, alternative medication, or dietary supplement without the knowledge of the campus nurse.

Start Date	Name of Medication/Amount Provided	Strength (i.e. 10 mg)	Dosage (i.e. 2 tabs or 1 tsp)	Time to be given

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Secondary students only:

_____Parent initials provide permission for their child to bring home medications other than controlled substances at the end of the school year.

PARENT/GUARDIAN CONSENT:

I give my permission for the above medication to be given to my child at school or on school sponsored field trips, as applicable. I understand that the medication may be given by an authorized KISD employee. I consent to and authorize the healthcare provider to disclose health information to the school, and for the school to disclose the above information to those within the school district that have a need to know for legitimate educational purposes.

_____

Parent/Guardian Signature **Contact #** **Date**

_____

Physician's Signature **Phone #** **Date**

Updated 8-2024