WILLIS ISD

A.R. Turner Elementary

PHYSICIAN'S ORDER AND PARENT PERMISSION FOR PRESCRIPTION AND NON-PRESCRIPTION MEDICATION FOR SCHOOL YEAR 2024-2025 ONLY

PHYSICIAN AND PARENTS: The purpose of administering medications at school is to assist students who require medication during school hours to maintain an optimal state of health and, therefore, enhance their educational program.

MEDICATIONS SHALL BE ADMINISTERED ONLY WHEN THE STUDENT'S HEALTH REQUIRES THAT THEY BE GIVEN DURING SCHOOL HOURS. NO MEDICINE WILL BE TRANSPORTED ON BUSES WITHOUT A PHYSICIAN'S ORDER TO SELF CARRY AND CLEARANCE FROM THE CAMPUS NURSE. ALL MEDICATIONS NOT PICKED UP BY THE LAST DAY OF SCHOOL WILL BE DISCARDED. NO MEDICATIONS WILL BE KEPT OVER THE SUMMER. Medications that are administered at school must be in properly labeled prescription or original over-the-counter packaging with the dosing instructions/guidelines. ***Over-the-counter medications AND prescription medications both require a physician's order. ALL medications (Rx and OTC) require this medication form signed by the parent and physician.*** ****ASK YOUR PHARMACIST TO GIVE YOU TWO LABELED BOTTLES, ONE FOR HOME AND ONE FOR SCHOOL****

Sincerely,
Nurse Bardwell
Phone: 936-856-1295
Fax: 936-890-1487
Email: lbardwell@willisisd.org

THE FOLLOWING SHOULD BE COMPLETED BY THE PHYSICIAN AND RETURNED TO THE NURSE BY FAX OR BY THE PARENT.

DATE:_____ STUDENT'S NAME:_____

IS TO RECEIVE_____
MEDICATION, DOSAGE, ROUTE, TIME(S) THIS NEEDS TO BE A COMPLETE ORDER

FOR THE TREATMENT OF_____FURTHER INSTRUCTIONS _____

_____

PHYSICIAN NAME: _____ PHYSICIAN SIGNATURE: _____

PHONE: _____FAX: _____

ADDRESS or PRACTICE NAME: _____

I HEREBY GIVE MY PERMISSION FOR MY CHILD TO RECEIVE THE ABOVE MEDICATION AT SCHOOL AND GIVE THE NURSE/MEDICATION AIDE PERMISSION TO NOTIFY HIS/HER TEACHERS, COUNSELORS, AND, PRINCIPALS THAT NEED TO BE AWARE OF THIS CONDITION.

_____
PARENT/GUARDIAN