Sabine ISD - Request for Medication Administration

This form must be signed by a physician for any medication to be administered during school hours including prescription and over the counter medications.

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: _____

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:

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