

## Weslaco Independent School District Medication Request Form

Please follow the guidelines below when bringing medication to school:

1. For student safety, all medication should be brought to the school by the parent. **Controlled substances must be brought to the clinic by the parent.** Medications are not provided by the school.
2. **All medication must** be in its original, properly labeled container with a written request signed by the parent/guardian, **PHYSICIAN'S SIGNED ORDER**, and must be administered according to the labeled instructions or a medical order.
3. Only medication that cannot be given at home will be given at school.
4. Only a 30 day supply of medication will be accepted at a time. (Amount received by nurse \_\_\_\_\_)
5. **Medication that has expired or is not picked up by the parent will be destroyed.**
6. Authorized district employees may administer medication in the absence of the nurse.
7. Aspirin or products containing aspirin will not be given without a physician's order.
8. Nonprescription, homeopathic medication, dietary supplements and herbal supplements will only be given in accordance with Weslaco ISD Board Policies FFAC (LEGAL) and FFAC (LOCAL)

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Allergies: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time(s): \_\_\_\_\_

Medication shall start date: \_\_\_\_/\_\_\_\_/\_\_\_\_ end date \_\_\_\_/\_\_\_\_/\_\_\_\_

Will this be the first dose of a new medication for your child? \_\_\_\_\_ Yes \_\_\_\_\_ No

Diagnosis: \_\_\_\_\_ Purpose of Medication: \_\_\_\_\_

Special Instructions/adverse reactions/side effects for this medication: \_\_\_\_\_

The Superintendent shall designate the employees who are authorized to administer medication that has been provided by a student's parent. An authorized employee is permitted to administer the above medication in accordance with administrative regulations:

1. Prescription/Over the counter medication in accordance with legal requirements.
2. Nonprescription medication, upon a parent's written request and physician's signature, when properly labeled and in the original container.
3. Herbal substances or dietary supplements provided by the parent and only if required by the individualized education program or Section 504 plan for a student with disabilities.

### Licensed Healthcare Provider Statement

**By my signature below, I affirm that it is impossible to schedule the above mentioned medication at a time other than school hours.** I request that this medication be given by a school employee. I acknowledge that I will not hold the Weslaco ISD, Board of Trustees, and / or District employees for damages or injuries resulting from administration of this medication (prescription / nonprescription / homeopathic / over the counter, dietary supplement and / or herbal supplement.

Physician's Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize school personnel to assist my child in taking medication. I, \_\_\_\_\_, give permission for my child to receive the medication ordered by the above Health Care Provider.

Parent Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_