Health Services

Coldspring-Oakhurst COCISD

PHYSICIAN/PARENT REQUEST FOR ADMINISTRATION OF MEDICATION 0R SPECIAL PROCEDURE BY COLDERING OAKHURST ISD SCHOOL PERSONNEL

Special health care procedures and medications may be prescribed for administration by school personnel as follows:

- When such treatment cannot otherwise be accomplished.
- **Once a day medications can be given at home before or after school; twice a day medications can be given at home before and after school. Three times a day medications can be given at home before school, after school, and at bedtime. Four times a day medications should be given at home and school. (Please have pharmacy give 2 bottles; one for school & one for home.).**
- Medications must be brought to the campus clinic by parent or legal guardian, at which time the medication/special procedure form will be completed. Special equipment items should also be supplied by the parent.
- Medications can be given for a time period no longer than the time period stated on the medication label.
- Prescription medication must have a current pharmacy label with the student's name and dosing details (name of medication, dose, time the medication/treatment should be administered).
- Over the counter medications must have dosage information included for the student age/height/weight and be in the original unopened container.
- All medication (prescription and over-the-counter) will require a physician's order in order to be administered in the health clinic.
- In-school medication/treatment may be administered by unlicensed assistive personnel/designee of the principal or district Nurse.
- This information will be handled confidentially and may be shared with appropriate faculty and staff that work directly with your child.
- If medication is requested by student and is within a time-frame that medication could have been given at home, it should be verified that medication can be given.

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Name of Student _____ DOB_____
Parent/Guardian_____ Phone _____

PHYSICIAN TO COMPLETE

1. Condition for which prescribed treatment/medication is required:
   _____
2. Specific medication or procedure:
   _____
3. Dosage, Method and Time of administration:
   _____
4. Precautions, unfavorable reactions:
   _____
5. Disposition of student following administrations or procedure, if applicable (i.e. rest, home, hospital, doctor's office, return to class):
   _____
6. Date of request_____ Date of termination_____.

With Doctor approval only:
YES___NO___This student must carry this medication at all times due to a life threatening condition.
YES___ NO___ This student has full knowledge/understanding of this medication, proper therapeutic use, proper administration, and side effects.
YES ____ NO ____ An additional form (Contract for Self-Administration) should be completed by the student. Self-Carry Emergency Medications should have a pharmacy label attached to the medication at all times.

Physician's Signature:_____ Date:_____

Printed Physician's name_____
Address:_____ Phone:_____
_____ Fax:_____
Pharmacy:_____ Phone:_____

PARENT/GUARDIAN CONSENT

I, the undersigned, the parent/guardian of (Student Name) _____. Request the above medication/treatment be administered to my child.
Parent/Guardian Name Printed: _____

Signature:_____ Date:_____

SCHOOL CLINIC USE ONLY

Filed in clinic on_____by_____