WILLIS ISD

ONE TEAM - ONE PURPOSE

WILLIS ISD

PHYSICIAN'S ORDER AND PARENT PERMISSION FOR PRESCRIPTION AND NON-PRESCRIPTION MEDICATION FOR SCHOOL YEAR 2025-2026 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. ***All prescription medications require a physician's order. Over-the-counter medications will be kept in the clinic no longer than 10 school days. Any OTC medications needing to remain in the clinic longer, will require a physician signature. ALL medications (Rx and OTC) require this medication form signed by the parent.*** ****ASK YOUR PHARMACIST TO GIVE YOU TWO LABELED BOTTLES, ONE FOR HOME AND ONE FOR SCHOOL****

Sincerely,

WILLIS ISD HEALTH SERVICES

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 AND OTHER STAFF THAT NEED TO BE AWARE OF THIS CONDITION.

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PARENT/GUARDIAN