JUNCTION INDEPENDENT SCHOOL DISTRICT

Request For Medication Administration

Student: _____ DOB: _____ Grade: _____

Medication: _____ Dose: _____

Take Medication: ___ By mouth ___ Inhaler ___Topical (cream)___ Injection

Other: _____

Condition for which medication is given: _____

To be given: ___ School year or the following dates: _____

When to be given: _____

Consideration/Side effects: _____

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: _____
Printed Name: _____	
Quantity Received: _____	Expiration Date: _____
Returned to: _____	Date: _____
Amount Returned: _____	

Date	Time Given	Initials	Date	Time Given	Initials

Signature: _____ Initials: _____

Signature: _____ Initials: _____

Signature: _____ Initials: _____

08/2025