DENISON INDEPENDENT SCHOOL DISTRICT

REQUEST FOR MEDICATION ADMINISTRATION

Student Name: _____ **Student DOB:** _____

PARENT/GUARDIAN AUTHORIZATION

Name of Medication: _____

By signing below, I acknowledge that:

_____ ***(initial)*** *I give permission for designated Denison ISD personnel to administer this medication in accordance with the authorized physician/provider's order on the associated Action Plan (asthma, allergy, or seizure) or Diabetes Management and Treatment Plan (DMTP).*

_____ ***(initial)*** *I give permission for designated Denison ISD personnel to administer medication in accordance with the authorized physician/provider's order.*

- *I have read and understand the Denison ISD Medication Procedures*
- *I give consent for the school nurse to provide ongoing assessment and intervention related to my child's condition, including monitoring the effectiveness of the prescribed medication and assessing for any side effects or adverse reactions.*
- *I give permission for the school to contact the ordering health care provider about the administration of this medication or the condition for which it is meant to treat.*
- *I understand that the School District, the Board and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medication to a student, provided such administration conforms to the requirements of the Districts medication policy.*

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to Student: _____

Phone Number: _____ E-Mail: _____

PHYSICIAN/PRESCRIBING HEALTHCARE PROVIDER ORDER

Medication: _____

Strength: _____ Dose: _____

Take medication: ☐ by mouth ☐ inhalation ☐ topical (cream) ☐ injection _____ ☐ other_____

When: ☐ at the following time(s)_____- or - ☐ as needed every_____hours ☐ May repeat_____

Order valid: ☐ Entire School Year - or - ☐ the following dates:_____ to _____

Diagnosis (ICD-10) and symptom for which medication is given: ☐acute ☐ chronic _____

Special Considerations/Side Effects: _____

List any drug allergies: _____

Physician Signature: _____ Date: _____

Printed Name: _____ Phone Number: _____