



Physician/Parent Request for Administration of Medication/ Procedure by Huffman ISD Personnel

Name: _____ DOB: _____ Grade: _____ Student ID: _____ Allergies: _____

Special Healthcare procedures and medication may be prescribed for administration by school personnel as follows:

1. When such treatment cannot otherwise be accomplished
2. On receipt of this completed form along with prescription and/or special equipment items. Prescribed in-school medication/ treatment may be administered by non-health professional designate of the principal

In compliance with HISD policy, all medications administered by HISD staff must be:

1. Delivered to the clinic by a parent/guardian or designee (responsible adult).
2. Supplied in the original container (prescription bottle with prescription label OR manufacturer’s packaging and will only be administered in accordance with prescriber/ manufacturer guidelines).
3. Prescribed by a medical professional licensed with prescriptive authority in the State of Texas. Unless FDA approved medication available for purchase without a prescription for up to 10 days.
4. US FDA approved for safety and efficacy (school nurse may decline administration if he/she finds the dose to exceed current best practice or the medication is otherwise potentially harmful to the recipient).
5. Must be retrieved from the clinic by a parent/ guardian or designee (responsible adult) by the last calendar day of the current school year or medication will be destroyed in accordance with district expectations.

I request Huffman ISD personnel to administer the medication listed below for the **20**__-**20**__ school year:

Medication: _____ **Dose:** _____ **Route:** _____

Time: _____ **Expected Discontinue Date:** _____ **Expiration Date:** _____

Reason: _____ **Side Effects:** _____

I, _____, the undersigned _____ (relationship) of the student listed above, authorize the administration of the medication listed above for the current school year and authorize the school nurse or his/her designee to contact the prescribing healthcare provider for any clarification regarding the requested medication administration.

Signature: _____ **Date of Request:** ____/____/____

Parent/ Guardian Phone Number: _____ **Parent/ Guardian Email:** _____

Printed Physician’s Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

Physician Signature: _____ **Date:** _____

Pharmacy: _____ **Prescription #** _____ **Pharmacy Phone:** _____

