



Medication Administration Request School Year 2026-2027

Student's Name _____ GRADE _____ DOB _____ ID# _____

Medication Allergies: ☐ None _____

ORIGINAL PRESCRIPTION (HOME ORDER)

Statement: This section reflects the original provider prescription as dispensed by the pharmacy.

Medication Name (as on pharmacy label): _____

Dosage: _____ Route: _____ Time: _____

SCHOOL ADMINISTRATION ORDER FOR SCHEDULED MEDICATIONS

Statement: This section is what the school nurse will administer during school hours for the above medication.

Dosage: _____ Route: _____ Time: _____

☐ after lunch

Inhalers ☐ Prior to physical activity

Indication reasons/diagnoses: _____

Start Date: _____ End Date: _____

Is the above order an emergency rescue medication? ☐ Yes ☐ No

Is the student capable and allowed to self-carry? ☐ Yes ☐ No

If YES, fill out the medication self-carry agreement form 499-131-A

☐ Medication is also scheduled PRN. Minimum time between doses _____

FOR OVER THE COUNTER MEDICATIONS

Medication Name: _____

☐ OTC medications are to be administered per manufacturer's labeled directions unless otherwise directed below.

Dosage: _____ Route: _____ Time: _____

Indication (reason): _____

Special Instructions / Parameters: _____

Start Date: _____ End Date: _____

PROVIDER ACKNOWLEDGEMENT

I acknowledge that the school administration schedule may differ from the pharmacy label (original home orders) and is medically appropriate for this student during school hours.

Physician's Signature: _____ Date: _____

Name Printed: _____ Name of Office: _____

Phone: _____ Fax: _____

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P A R E N T	PARENT / LEGAL GUARDIAN AUTHORIZATION	
	My signature below indicates that I request WFISD staff (may include trained non-medical personnel) to administer the medication specified to my child, and I am giving permission for WFISD staff to contact the physician for additional information, if needed. I consent to and authorize the health care provider to disclose health information to the school, and for the school to disclose information to those within the school district who have a need to know for legitimate educational purposes.	
	☐ I acknowledge that I have read, understood, and signed the Medication Policy	
	☐ Yes-Student may take morning dose of medication at school, if forgotten at home, <u>with parent permission by phone</u>	
	Parent/Legal Guardian Name: _____	
	Signature: _____ Date: _____	
Phone Number: _____		

WFISD STAFF ONLY

SCHOOL NURSE VERIFICATION

- ☐ ____ (nurse initial) Medication label matches drug and strength of provider order
- ☐ ____ (nurse initial) Any discrepancies clarified with provider and/or parent
- ☐ ____ (nurse initial) Medication received in properly labeled container

Comments: _____

Nurse Signature who accepted the order/medication: _____ Date: _____

Medication/Procedure Order Reviewed by Supervising RN: _____ Date: _____

Receive/Return Medication

Document witnessed pill count of medication received, returned to parent, or intra-district transfer to new campus.

Count at both sending and receiving campus. Witness: parent/guardian or WFISD staff.

Medication Count: (All Medications Must Be Counted)							
Date	Medication	Amount Received	Amount Returned	Amount in clinic	Total	Witness Signature	Nurse Signature