



Received Form On: _____

Received By: _____

Request and Consent for Medication Administration

Student Name: _____ DOB: ____/____/____ Student ID#: _____

Campus: _____ Teacher: _____ Grade: _____

Medication Allergies: _____ ☐ No Known Drug Allergy

Health Care Provider Authorization

Medication: _____ Dosage: _____ Route: _____

Condition for which medication is administered: _____

Time(s) to be Administered: _____ Medication Expiration Date: _____

Dates of Administration: From _____ To _____ OR ☐ Duration of School Year

Known Side Effects/ Special Instructions: _____

Physician's Printed Name: _____ Phone: (____)-____-____

Physician's Signature: _____ Date: _____

Parent/ Guardian Authorization

All first doses of medication must be administered at home. Has your child taken this medication before? ☐ YES ☐ NO

Medication Return: Please indicate how you would like the medication to be returned home.

*** Any medication not picked up by the last day of school will be disposed of by the school nurse, per protocol.

☐ ☐ Send home in my child's backpack

*** Controlled substances and EpiPens must be transported by a parent/ guardian and will not be released to students.

☐ ☐ The parent/ guardian will pick up the medication from the clinic

☐ ☐ Do not return the medication. Please discard any remaining doses.

By signing below, I acknowledge that:

1. I give permission for designated Pflugerville ISD personnel to administer this medication in accordance with the health care provider's instructions above and PfISD Medication Policy.
2. I have read, understand, and agree to abide by the Pflugerville ISD Medication Policy, available on the Health Services website.
3. I give the school permission to contact the healthcare provider listed above regarding administration of this medication.

Parent/ Guardian Signature: _____ Date: _____

* Please Note: Orders must be renewed each school year*

Revised 05/2026



Medication Inventory							
* When Receiving or Returning Medication to a Parent *							
Date	Count	Counter's Signature	Witness Initials	Date	Count	Counter's Signature	Witness Initials

Weekly medication inventories should be documented in Skyward

Offline Documentation of Medication Administration			
Date	Time	Reason	Nurse Signature

Reason Codes:
 COM= Computer Downtime SUB= Substitute Nurse STU= Student Nurse UAP= (Authorized) Unlicensed Assistive Personnel

Medication Returned To: _____ Date: _____
Parent/ Guardian/ Student Signature