

POTH INDEPENDENT SCHOOL DISTRICT



2026-2027 Medication Administration Request Form

STUDENT/ ID#: _____ DOB: _____ GRADE/TEACHER: _____

SPECIAL INSTRUCTIONS FOR ADMIN: _____

- THIS FORM MUST BE FILLED OUT AND SIGNED BY A HEALTHCARE PROVIDER FOR ANY MEDICATION (OTC OR PRESCRIPTION) TO BE ADMINISTERED AT SCHOOL
- MEDICATION (INCLUDING REFILLS) **MUST** BE DROPPED OFF BY A PARENT / GUARDIAN / ADULT DESIGNEE
- MEDICATION **MUST** BE DROPPED OFF IN ORIGINAL BOTTLE WITH PHARMACY PRESCRIPTION LABEL (WHEN APPLICABLE)
- **PHARMACY LABEL MUST INCLUDE:** STUDENT NAME, NAME OF MEDICATION, DOSE TO BE GIVEN, TIME OF ADMINISTRATION, ANY OTHER SPECIAL INSTRUCTIONS
- PHARMACY LABEL **MUST** MATCH PHYSICIAN ORDER / INSTRUCTIONS
- MEDICATION **MUST** NOT BE EXPIRED
- VITAMINS / HERBAL SUPPLEMENTS / ESSENTIAL OILS **WILL NOT** BE ADMINISTERED AT SCHOOL

MEDICATION/ REASON	DOSE	TIME	ROUTE	HOW LONG

I give permission for Poth ISD school personnel to give the listed medication to the above named student during school hours. I understand per Section 22.052 (2) of the Texas Education Code that the school district, its board of trustees and its employees are not liable for damage or injuries resulting from the administration of this medication. In addition, the licensed school nurse has the responsibility and authority to refuse to administer medications that, in the nurse's judgment, are not in the best interest of the student. (Board of Nurse Examiners Rule, 22 Texas Administration Code 217.11).

PARENT/GUARDIAN SIGNATURE

DATE

PRINTED NAME

CONTACT PHONE NUMBER

PHYSICIAN ANNUAL PRESCRIPTION AUTHORIZATION

(ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS MUST HAVE A HEALTHCARE PROVIDER'S SIGNATURE)

AUTHORIZED SIGNATURE

DATE

PRINTED NAME

OFFICE PHONE NUMBER

****ORDER VALID FOR CURRENT SCHOOL YEAR AND MUST BE RENEWED ANNUALLY****

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2026-2027 Medication Drop Off/ Pick Up

Medication and Amount	Expiration	Drop off (sign and date)	Pick up (amount, sign, and date)