ANDREWS ISD

Parent Request For Administration Of Medication By School Personnel

Name of Student _____ Date of Birth _____

Parent/Guardian Name _____

Teacher _____ Grade _____ ID# _____

Condition for which medication is to be given: _____

Name of medication: _____

Dosage: _____ Time to be given: _____

How long will medication be given? _____

Special Instructions: _____

_____

I certify that it is necessary to give the above medication during school hours and that it is provided in the original container. It may be administered by a medically untrained designate of the school principal.

Medication must be picked up by a guardian at the end of the school year, if not, medication is disposed of.

_____

Signature of Parent/Guardian Date

_____

Home Phone # Work #

Medication and permission received by: _____

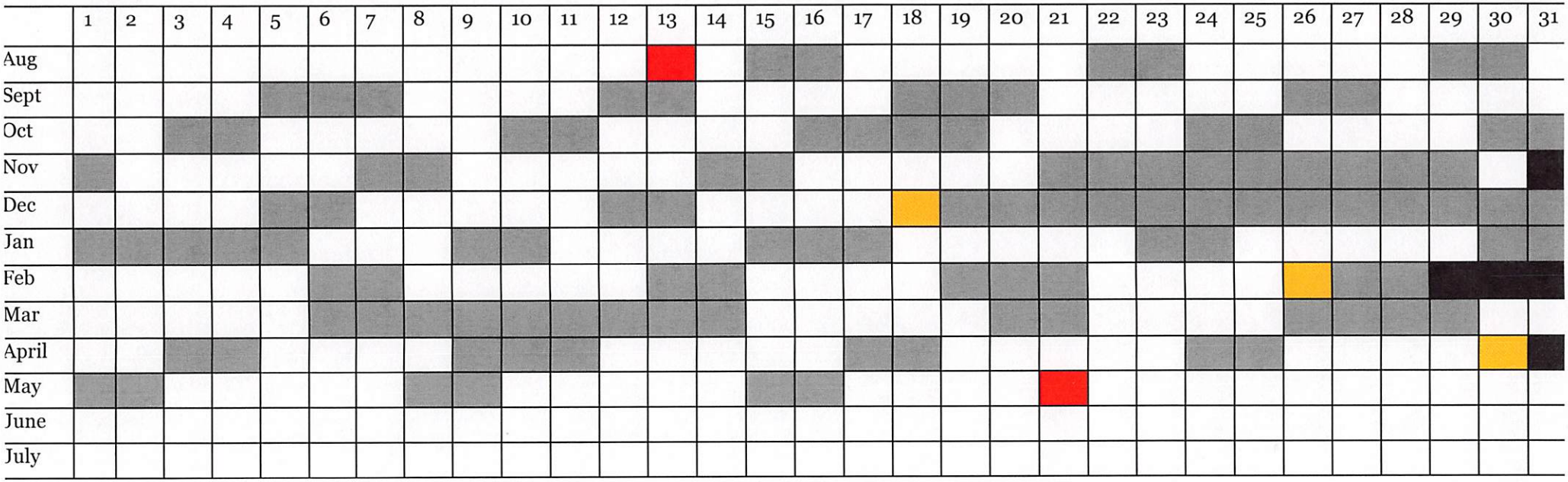
Date Received: _____

Medication Log 2026-2027

Last Name_____First Name_____Teacher_____

Medication_____Start Date_____End Date_____

Dose_____Time_____Route_____Prescribed By_____



Notes

Medication Count

Date	Count	Date	Count

Codes

A= Absent
NA = None Available
NS = No Show
H = Hold
R = Refused

= 1st and last day of school
= No School
= Bad Weather Day/Early Dis.

Initials	Signature