OTC Medication Administration in School

Revised 2026

This form is valid for the current school year: 20_____ - 20_____

Student Information

Student Name: _____ Date of Birth: _____ Student ID#: _____

Grade: _____ HR Teacher: _____ Diagnosis: _____

Medication Name: _____ Expiration: _____

Manufacturer's Administration Instructions: _____

_____

NOTE: Non-prescription (over-the-counter) medication will only be administered according to the manufacturer's instructions printed on the medication container. Any variation outside of the suggested instructions must be accompanied by a written medication order signed by a physician who is licensed to practice medicine in the State of Texas.

Medication Requirements

Galena Park ISD requires the following:

- ☐ Only those medications that are medically necessary during school hours for a student's attendance or written in an IEP should be administered at school
- ☐ A written request to administer medication dated for the CURRENT school year signed by the parent/legal guardian or other person(s) having legal authority of the student
- ☐ Medication brought by the parent/guardian or responsible adult in the original, new or unopened container, with a non-expired date.

Physician Order for OTC Medication Administration Outside Manufacturer's Instructions

Medication Name	Strength	Dose	Time(s) to be Administered

☐ Dose can be repeated _____ times in a school day

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Authorization

Physician Authorization:

I authorize the administration of the above-named medications/treatments to this student during school hours.

Physician Signature: _____ Date: _____

Physician Name (printed): _____ Physician Phone: _____

Parent/Guardian Authorization:

My signature below indicates that I request GPISD staff or contracted outside agency staff to administer the medications/treatments specified above to my child, and I am giving permission for GPISD staff or contracted outside agency staff to contact the physician for additional information, if needed. *Mi firma a continuación indica que solicito al personal de PISD o al personal externo contratado de la agencia que administre la medicación indicada para mi hijo(a), y le estoy dando permiso para el personal PISD o contratada fuera del personal de la agencia en contacto con el médico para información adicional, si es necesario.*

- ☐ I have provided the school with the correct medication/dosage in its original container.
- ☐ I understand a new form is needed for all changes in medication, dose, or time.
- ☐ I understand all medication shall be brought to the school by a parent/guardian or responsible adult.
- ☐ Unless otherwise specified, this order is valid for the entire school year including summer session if applicable.
- ☐ Expired and discontinued medication not picked up by the last day of school will be destroyed.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (printed): _____ Phone: _____

Medication Inventory Record

Date	Amount Received (count with parent/adult)	Signature of Person Bringing Medication	Signature of School Employee Receiving Medication	Expiration Date

Date	Amount Returned	Signature of Person Medication Returned to	Signature of School Employee Receiving Medication	Comments

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