Prescription Medication Administration in School

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: _____

**Please have physician complete a separate form for each medication or treatment to be provided during the school day.*

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
- ☐ A written medication order signed by a physician who is licensed to practice medicine in the State of Texas (this form or another order completed by the physician).
- ☐ Medication brought by the parent/guardian or responsible adult in the original, properly labeled container from a registered pharmacists and not expired.

Physician Orders for Medication Administration

Medication Name	Strength	Dose	Time(s) to be Administered

☐ Dose can be repeated _____ times in a school day

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: _____

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Revised 2026

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 GPISD 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 GPISD 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	Signature of School Employee Receiving Medication	Expiration Date

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

Controlled Prescription Medication Verification
(Required for Controlled Substances Brought to School)

Medication Detail	Description
DEA Schedule (if known)	II III IV V
Date Filled	
Medication Form	Tablet Capsule Liquid Chewable Patch Other: _____
Color	
Shape	
Imprint/Markings	