



SHERMAN

INDEPENDENT SCHOOL DISTRICT

Request for Medication Administration

Student: _____ DOB _____ Grade: _____ Campus: _____

Medication: _____ Dose: _____

Take medication: ☐ by mouth ☐ via inhaler ☐ topical (cream) ☐ injection ☐ other _____ Condition for which medication is given: _____

To be given: ☐ Entire School Year - or - ☐ The following dates: ____ / ____ / ____ to: ____ / ____ / ____ When:

☐ At the following time(s): _____ - or - ☐ As needed every _____ hours Special considerations/side effects: _____

For Daily Medications: ____ Yes, please send on field trips ____ No, please do not send on field trips Other medications taken at home: _____

List any food or drug allergies: _____

A parent/guardian and physician signatures are required for prescription medications. A physician's signature is needed if more than 10 doses of over the counter medication is given or if it contains aspirin.

Parent/Guardian: I give permission for district personnel to administer medication to my child in accordance with Texas Education Agency and District policies. I also acknowledge that it is the parent/guardian responsibility to maintain medication supply. Unclaimed medication will be destroyed at the end of the school year.

Signature: _____

Date: _____

Printed Name: _____

Phone: _____

Physician: I request that the student receive this medication during the school day as instructed above.

Signature: _____

Date: _____

Printed Name: _____

Phone: _____

School: Medication was received on: (date) _____

Staff Signature: _____

Quantity Received: _____

Parent Signature: _____

Expiration Date: _____