

Medication Administration Form

Date of Request: _____ School: _____ Teacher/Grade: _____

Student's Name: _____ Birth date: ____ / ____ / ____

Medication: _____ Exp Date: _____ Dosage: _____

Route of administration:

- ☐ By mouth
- ☐ Inhaled
- ☐ Topical
- ☐ Eye

- ☐ Ear
- ☐ Nasal
- ☐ Injection
- ☐ Rectal
- ☐ Gastrostomy

Time to be administered: _____ Dates to be administered: _____

Condition for which medication is required? _____

Has your child ever taken this medication before? YES/NO

Medication Allergies: _____

Special instructions or known side effects of medication for your child: _____

My signature below indicates that I request that CISD staff administer the medication specified above to my child as the physician prescribes. I am permitting CISD staff to contact the physician for additional information regarding this medication if needed. I understand this form is valid for the current school year only and that a new form must be submitted annually and for any changes to medication dosing instructions and times. I understand that for prescription medications, only a 30-day supply will be accepted at this time. Unused, discontinued, or expired medication must be picked up by the parent/guardian. I understand that medications not picked up will be disposed of at the end of the school year or within two weeks after discontinuation. *Parent-provided nonprescription medication may be given up to 10 times per year (and no more than 5 consecutive school days) without a physician's signature, per district policy. A physician's signature is required for all nonprescription medications to be given more than 10 times per year or for more than 5 consecutive school days.*

****A physician's signature is required for all prescription medications that must be kept at school.****

Parent/Guardian signature: _____

Physician name: _____ Phone: _____

Physician's signature: _____

CONTROLLED MEDICATION COUNT

	Date (DO/PU?)	Count	CISD Witness	Witness #2		Date (DO/PU?)	Count	CISD Witness	Witness #2
1					6				
2					7				
3					8				
4					9				
5					10				

Medication Picked up by parent (signature): _____ Date: _____

Medication disposed of (date): _____ Count Complete? YES/NO

RN Signature: _____

Witness Signature: _____

MAR *(The below MAR should be used during Skyward downtime or substitute coverage only.)*

	Date	Time	Amount	Initials		Date	Time	Amount	Initials
1					12				
2					13				
3					14				
4					15				
5					16				
6					17				
7					18				
8					19				
9					20				
10					21				
11					22				