DALLAS INDEPENDENT SCHOOL DISTRICT | Health Services

PHYSICIAN/PARENT REQUEST FOR
ADMINISTRATION OF MEDICINE OR SPECIAL PROCEDURE BY SCHOOL PERSONNEL

Special health care procedures and medications may be administered at school by designated employees of the district when such treatment is necessary for school attendance. Medication or special procedure may be administered by a school nurse or employees designated by the principal. The medication is administered either from a container that appears to be the original container and properly labeled by the pharmacy or from a properly labeled unit dosage container filled by a school nurse or designated district employee. This completed form along with the medication and/or special equipment items are to be brought to the school by the parent.

THIS INFORMATION IS CURRENT UNTIL NEW OR UPDATED INFORMATION IS RECEIVED OR FOR ONE CALENDAR YEAR FROM DATE OR UPDATE OF REQUEST.

FILED IN NURSE'S OFFICE ON _____ BY _____

1. Name of Pupil _____ Birth Date _____
2. Address _____ School _____
3. Condition for which prescribed treatment is required: _____ ICD 10 Code _____
4. Specific medication or procedure:
5. Dosage and method of administration/instruction, time(s) of day, requirements for special health care procedure.
6. Precautions, unfavorable reactions:

☐ Self-Administration of Asthma or Anaphylaxis Medicine

7. Disposition of pupil following administration or procedure, if applicable, i.e., rest, home, hospital, doctor's office, return to class.
8. Date of Request _____ Date of Termination _____
9. _____ / _____
   Physician's Name (printed) *Signature*
   _____ / _____
   Physician's Address *Telephone Number*

.....

We (I), the undersigned, the parents/guardians of _____ request the above medication or procedure be administered to our (my) child. We (I) authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed above.

Nosotros, los padres/los tutores de _____ solicitamos que el medicamento o procedimiento anterior se administre a nuestro (mi) hijo. Nosotros (yo) autorizamos según sea necesario el intercambio de infomación relacionada con la salud de mi hijo entre la enfermera de la escuela (o su designado) y el proveedor de atención médica mencionado anteriormente.

_____ / _____ Telephone _____ / _____
Name *Relationship* *Home* *Business*

_____ / _____ Telephone _____ / _____
Name *Relationship* *Home* *Business*

NOTE: Prescribed asthma or anaphylaxis medicine may be kept and self-administered by the student if the physician indicates this in writing and student is capable of self-administration.