Parent Request for Administration of Medication by School Personnel

CONROE INDEPENDENT SCHOOL DISTRICT
Health Services

Place Student Photo Here

CONFIDENTIAL

Date Entered in eSchool _____ Nurse Initials _____

Student Name _____ **ID#** _____

Student's Date of Birth _____ **Teacher** _____ **Grade** _____

As the Parent / Guardian of the above named child, I give my permission for him / her to be given the medication as described below by whomever the principal designates. I understand medication will be handled according to recommended Conroe ISD Policy and Procedure, TEA recommendations and FDA Guidelines.

Printed Name of Parent/Guardian _____

Signature _____ **Relationship to Student** (Ex. Mom, Step Parent, Etc.) _____

Daytime Phone Number(s) _____ **Today's Date** _____

Name of Medication			**Medication Strength**
Route of Administration: ☐ **by mouth** ☐ **inhaled** ☐ **topical** ☐ **eye(s)** ☐ **ear(s)** ☐ **nasal** ☐ **injection (circle: IM SQ IV)** ☐ **rectal**			
Dosage	**Reason for Taking**		
Give Daily **Time(s):**	**OR**	**Give PRN/As Needed** **Frequency:**	
Medication Start Date	**Medication End Date**		***Medication Expiration Date***
Special Instructions			
Other Medication(s) Student is Taking			
CHANGES	**Date**	**Change in Dose, Amount, or Time**	**Parent Signature**
	Date	**Change in Dose, Amount, or Time**	**Parent Signature**

MEDICATION CHECK-IN

Date Received	Amount/Number	Clinic Staff Signature	Parent/Guardian Signature
Original			
REFILL(S)			
#1			
#2			
#3			
#4			
#5			
#6			
#7			
#8			
#9			

Med. Pick-Up Date_____ **By** _____ **Relationship** _____ **Count** _____ **Staff Initials** _____