Received Form On ________________
Received By ____________________

Updated 5/2021

Parent/Physician Request for Administration of Medication by School Personnel

School: ______________________________ Teacher/Grade: ________________

Student's Name: ____

Student's ID#: ______________ Birth Date: _____ / _____ / _______

Medication: ______________________ Dosage: __________ Exp. Date: _______

Route of administration: ☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ injection (circle: IM SQ IV) ☐ rectal ☐ GT/JT

Time to be Administered: ________________

Dates to be Administered: _________ to Date _________ OR ☐ Entire school year

Condition for which medication is required: ______________________________

Has your child ever taken this medication before? YES NO *All first doses of medication must be administered at home.*

Medication Allergies: ☐ No Known Medication Allergies ☐ Allergic to: ______________

Special instructions or known side effects of medication: ____________________

____

Please indicate how you would like the medication to be returned home:

☐ Send home in my child's backpack*

**Controlled substances (such as Ritalin, amphetamine salts, etc.) and Epi-pens must be transported by a parent/guardian and will <u>not</u> be released to students.*

☐ Parent/Guardian will pick up med from clinic

☐ Do not return med, please discard any remaining doses

My signature below indicates the following 1) I request that PfISD staff administer the medication specified above to my child, and I am giving permission for PfISD staff to contact the physician for additional information, if needed, and 2) I have read the online medication policy located on the PfISD Health Services page and agree to abide by all policies.

Parent/Guardian Signature: __________________ **Date:** __________________

Parent's Primary Phone: (____) _____ - __________ **Email**: __________________

Physician's Name: __________________________ **Phone**: (____) _____ - __________

**A physician's signature is required to administer over-the-counter medications for <u>more</u> than 10 doses. Medications with a printed pharmacy label for the student do NOT require the physician's signature below.*

***Physician's Signature**: ______________________________ **Date:** ______________

Medication returned to: Parent / Student______________________________Date ______________
Parent/Student Signature

Off-line documentation

Date	Time	Reason	Nurse Signature

FOR OFFICE USE ONLY!

☐ Entered in Skyward

☐ Teacher Notified___/___

Medication Count When Receiving From Parent:

Date	# Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials

August	**Count**	**Signature**	**Witness Signature**	**September**	**Count**	**Signature**	**Witness Signature**
Week 1				Week 1			
Week 2				Week 2			
Week 3				Week 3			
Week 4				Week 4			
Week 5				Week 5			
October	**Count**	**Signature**	**Witness Signature**	**November**	**Count**	**Signature**	**Witness Signature**
Week 1				Week 1			
Week 2				Week 2			
Week 3				Week 3			
Week 4				Week 4			
Week 5				Week 5			
December	**Count**	**Signature**	**Witness Signature**	**January**	**Count**	**Signature**	**Witness Signature**
Week 1				Week 1			
Week 2				Week 2			
Week 3				Week 3			
Week 4				Week 4			
Week 5				Week 5			
February	**Count**	**Signature**	**Witness Signature**	**March**	**Count**	**Signature**	**Witness Signature**
Week 1				Week 1			
Week 2				Week 2			
Week 3				Week 3			
Week 4				Week 4			
Week 5				Week 5			
April	**Count**	**Signature**	**Witness Signature**	**May**	**Count**	**Signature**	**Witness Signature**
Week 1				Week 1			
Week 2				Week 2			
Week 3				Week 3			
Week 4				Week 4			
Week 5				Week 5			