Farmersville ISD - School Health Services
Prescription Medication Administration

PARENT'S REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION TO A STUDENT

Parents or guardians must adhere to the following guidelines:

1. ALL medication will be kept in the nurse's office.
2. Medications may only be given at school **if they cannot be scheduled before or after school hours.**
3. All prescription medications **MUST** be in the **original bottle**, with a pharmacy prescription label with the student's name. No more than **ONE MONTH'S SUPPLY** of medication, in a prescription labeled bottle, shall be brought to the school at one time.
4. Over-the-counter medications: must be age-appropriate, must be in the original container, and will be given according to the label on the package. **OTC meds will not be given longer than 10 days without Doctor's orders.**
5. ALL prescription and OTC meds will NOT be given without a doctor's note.
6. FISD will not administer any expired medications.
7. At the request of T.E.A., the school district will not provide any over-the-counter medications (i.e. Tylenol, ibuprofen, etc.)
8. **It is the student's responsibility to come to the nurse's office at the necessary time to take their medication.**

Note: We are unable to store any medications at the school during the summer & will dispose of all medicine left after the last day of school.

Name of Student:____ **Date of Request:** _______________

Student's Date of Birth: ____ **Grade:** ______________________

Campus: _______________________________________ **Homeroom Teacher/Class:** _________________________

Medication & Dosage: ____

Condition for which medication is to be given: ____

Amount to be administered: ____ **Time:** _________________

Special Instructions: ____

Discontinuation Date: ____

I consent to the release of the medical information contained on this form to school officials who have legitimate educational interest in the information, according to the Family Education Right and Privacy Act. I give my permission to release confidential information regarding my child's specific health problems to third parties, other than school officials, as required to facilitate medical care and/or treatment of my child. I authorize the nurse and the prescribing physicians to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

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Signature of Parent or Guardian Daytime Phone Number

Please have the physician complete this section if the medication is to be given for **longer than 10 days**.

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Printed Name of Physician Phone Number Physician Signature

****Student has been trained and observed in use of inhaler. The student should be allowed to carry inhaler with them at all times.**

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Physician Signature