Mesquite ISD Health Services

Parent Request for Administration of Medication by School Personnel

This request is intended only for medication that cannot be administered at home. Medication should be delivered to the campus clinic or office by the student's parent/guardian in the original container, not loose or in a baggie.

Permission is valid for the current school year and medication should be picked up at the end of each school year. Medication is not kept on campus during summer unless the student attends summer school. Unclaimed medication is destroyed at the end of each school year.

Please print using black or blue ink:

Campus: _____ Grade/Teacher: _____/_____

Student Name: _____ Date of Birth: _____

Prescribed by: _____ Telephone #: _____

Pharmacy: _____ Prescription #: _____

Student Drug Allergies: _____

Medication: _____ Strength: _____ Exp. Date: _____

Dosage: _____ Frequency: _____ Time: _____

Route: ☐ Oral ☐ Inhaled ☐ Topical ☐ Eye ☐ Ear ☐ Nasal ☐ Rectal ☐ Injection: Type _____

Reason for medication: _____

Is this the first dose of a new medication for your child? ☐ Yes ☐ No

Side effects for student, special instructions, other pertinent information: _____

_____

☐ **Student may be given the prescribed morning dose of medication, if forgotten at home, with telephone permission from parent.**

I confirm that it is not possible to administer this medication at home and hereby request that the medication listed above be administered by a Mesquite ISD employee.

I understand that the School District, its Board of Trustees, and its employees are immune from civil liability from damages or injuries resulting from administration of this medication (Texas Education Code 22.052).

I authorize the district registered nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per State law (Nurse Practice Act & Medical Practice Acts of Texas).

Parent/Guardian Signature: _____ Relationship: _____

Daytime telephone number: _____

Sample medication, over-the-counter medication, or instructions differing from the medication prescription label require a separate physician's order or physician's signature below.

_____ _____

Physician's Signature & Printed Name Telephone Number

FOR OFFICE USE ONLY

Date	# Pills	Counter Signature	Witness Signature	Date	# Pills	Counter Signature	Witness Signature

Revised 7/2015