

WYLIE INDEPENDENT SCHOOL DISTRICT
Parent/Physician Request for
Administration of Medication by School Personnel

2009-2010

Date of Request: _____ School: _____

Student's Name: _____ Teacher/Grade: _____

Medication: _____ Dosage: _____

Is this the initial dose of a new medication that has not been previously administered to your child? YES NO

Times to be administered: _____ Dates to Administered: _____

Condition for which medication is required: _____

Special Instructions/Precautions/Side Effects of medication on your child: _____

Physician's Name: _____ Phone: _____

*Physician's Signature: _____

My signature below indicates that I request that WISD staff administer the medication specified above to my child. I give my permission for WISD staff to contact the physician for additional information, if needed.

Parent/Guardian Signature: _____ Email: _____

Parent's Home Phone: _____ Work Phone: _____

**Over-the-counter medication will be given for no more than 5 school days. After that a note from the student's physician may be required for continued administration at school.*

FOR OFFICE USE ONLY!

Medication Count:

| Date | # Pills | Counter's Signature | Witness Initials | Date | # Pills | Counter's Signature | Witness Initials |
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Comments (Indicated by * on back of form):

| Date | Comments | Date | Comments |
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| Date | RN Review |
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Signature of Person Administering Medication

Initials

