

**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

**Comments (Indicated by \* on back of form):**

Date	Comments	Date	Comments

Date	RN Review

**Signature of Person Administering Medication**

**Initials**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_