2009-2010

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

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: ________________________

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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 or Counting **Initials**

____ ________________

____ ________________

____ ________________