TYLER INDEPENDENT SCHOOL DISTRICT

Parent/Physician Request for
Administration of Medication by School Personnel

Medication may be administered by school personnel as follows:

1. When such treatment cannot be accomplished except during school hours
2. On receipt of this completed form along with the medication
3. Prescribed by a physician/dentist and in the original container with the pharmacy label---please request the pharmacist to dispense two labeled bottles of medication---one for home and one for school

Date of Request:____________________

School:____ Teacher/Grade:___________________________________

Student's Name: _______________________________ Birth date:____

Medication:____________________________________Exp.Date________________Dosage:__________________________

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

Time to be Administered:_______________________________________ Dates to be administered:_____________________

Date of Termination:_________________ Known drug allergies:____

Condition for which medication is required:____

Special Instructions/Precautions/Side Effects of Medication:____

Physician's Name:____________________________________ Phone:____

*Physician's Signature:____

My signature below indicates that I request that TISD staff administer the medication specified above to my child, and I am giving permission for TISD staff to contact the physician for additional information, if needed. I also give my permission for information regarding this medication to be shared with school personnel on a need-to-know basis.

I understand that parents are to pick-up all medications by 3:00 on the last day of classes and that all medications remaining after that time will be discarded.

Parent/Guardian Signature:__________________________________ E-mail:____

Parent's Home Phone:______________________________________ Work Phone:___________________________________

**Physician's signature is required to administer over-the-counter medications.*
The prescription label on prescription medications will serve as the physician signature.

Only a 30-day supply of medication will be accepted at a time.

FOR OFFICE USE ONLY

Medication Count:

DATE	# PILLS	COUNTER SIGNATURE	WITNESS SIGNATURE		DATE	# PILLS	COUNTER SIGNATURE	WITNESS SIGNATURE