IRVING INDEPENDENT SCHOOL DISTRICT
Request for Administering Over-The-Counter Medications by School Personnel

Student's Name___________________________ Date of Birth_________

Known Diagnosed Allergies_______________________________________

Current Medications____

Significant Medical History (Pregnancy, Breastfeeding, Diabetes, etc.)____

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OTC Medication to be given___________________________________

Medication must be in the original **unopened** container labeled with the student name.
Labels on over-the-counter medications must designate contents as MEDICATION.

Reason for Giving____

Dosage____

Dosage must be within the recommended amount as stated on label.

Time to be given___________________ Dates to be given__________

Medications are given during school hours only.

Has student taken this medication before?_______________________

Medication expiration date______________________________________

A physician's written request is required if medication is to be given more than five(5)consecutive school days.

Home Phone _____________ _________________________________
Parent's Signature

Work Phone _____________
Date

NOTE: PLEASE INDICATE BELOW YOUR PREFERENCE REGARDING ANY UN-USED PORTION OF YOUR CHILD'S MEDICATION.

_____ Parent will pick up medication.
_____ Send medication home with student.

Date Medication Received __________

5.3b **updated 1/08**