

**IRVING INDEPENDENT SCHOOL DISTRICT HEALTH SERVICES
REQUEST FOR ADMINISTRATION OF PRESCRIPTION MEDICATION
BY SCHOOL PERSONNEL**

STUDENT NAME _____ STUDENT# _____ BIRTHDATE _____

SCHOOL _____ TEACHER _____

NAME OF MEDICATION _____ Exp. _____
Date _____

PHARMACY NAME & PRESCRIPTION NUMBER _____

DOSAGE _____

TIME TO BE GIVEN AT SCHOOL (DURING SCHOOL HOURS) _____

DATE MEDICATION STARTS _____ DATE MEDICATION ENDS _____

SPECIAL INSTRUCTIONS, POSSIBLE REACTIONS, IF ANY _____

**No medication will be dispensed for a missed dose unless written authorization is received.
Prescription inhalant medication may be carried by the student if directed in writing by the
Physician and Parent. (Use form 5.11 Asthma Inhalers at School)**

Parent Consent: I consent to and authorize the health care provider to disclose health information to the school, and for the school to disclose the above information to those within the school district who have a need to know for legitimate educational purposes.

Medications will be dispensed during school hours only.

Home Phone No. _____

PARENT/LEGAL GUARDIAN SIGNATURE

Work Phone No. _____

DATE

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

- _____ PARENT WILL PICK UP MEDICATION
- _____ SEND MEDICATION HOME WITH STUDENT
- _____ SCHOOL WILL PROPERLY DISPOSE OF ANY REMAINING MEDICATION AT THE END OF SCHOOL YEAR

Date Medication Received _____ Quantity received _____ Date Form Filed _____

By _____ Computer Entry _____

Initial & Date

Refill date _____ Quantity received _____ Received by _____

Refill date _____ Quantity received _____ Received by _____

Refill date _____ Quantity received _____ Received by _____

Refill date _____ Quantity received _____ Received by _____

Refill date _____ Quantity received _____ Received by _____

Refill date _____ Quantity received _____ Received by _____

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