PARENT REQUEST FOR ADMINISTRATION OF
MEDICATION BY SCHOOL PERSONNEL

- All prescribed and over the counter medication must be in a container labeled by the pharmacist or prescriber for the named student.
- Non prescription or over the counter medications must be age/wt appropriate, in the original container (NO BAGGIES) with the label intact and the student's name clearly written.
- The medication may be administered by a designate of the principal.
- A separate permission form is required for each medication.
- No expired medications will be accepted or administered.
- Sample medication will be accepted only with written directions from the physician.
- All medication not picked up by the parent on or before the last day of school will be discarded.

Student Name: ______________________________ DOB/Age: ________ Grade:_____ Teacher:_________

Medication: ______________________________________ Strength(mg): _________ Exp date: __________

Physician: _______________________________________ Prescription #: _____________

Condition for which medication is to be administered: ____

Specific Instructions: ____

Route of Medication: ORAL TOPICAL INHALANT INJECTABLE OTHER ___________

When to Administer: Dosage may not exceed recommended dose without written instructions.

_____ DAILY _______ ONE TIME DOSE ________ AS NEEDED (PRN)

Time to be given: _________________ Dosage: ________ tab cap tsp tbsp puffs vial ml (circle one)

Administer this medication until: _____ end of school year OR _____ specific date ___/___/______

I authorize, as needed, the sharing of information regarding my child's health between the school nurse, Wylie ISD faculty/staff and the prescribing health care provider to ensure his/her health and safety during school hours.

I give my consent for the above medication to be administered to the above named student by Wylie ISD school personnel. I release Wylie ISD and their employees from any liability in dispensing the above medications.

Parent Signature: ______________________________ Phone: ___________ Date: ____________

Physician Signature: ____________________________ Phone: ___________ Date: _____________