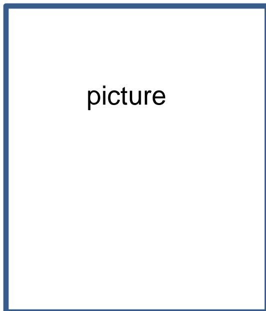
Lewisville ISD Health Services

Parent Request for Administration of Medication by School Personnel

SECONDARY



Name ______________________________ DOB ____/____/____ ID#______________

School ______________________________ Teacher/Grade __________________________

- Only medications that cannot be given outside the school hours will be administered.
- All medications must be in the original, current, properly labeled container with clear and legible instructions.
- Prescription labels must include: brand/generic name of drug, strength, manufacturer, pharmacy address, name of student and prescribing physician, date dispensed, expiration date of drug, and clear instructions for use, including specific times to be given.
- All medications to be administered at school must be FDA approved. Supplements, herbals, vitamins, homeopathic, and other non-regulated substances will not be given.

Condition for which medication is required: ____

Does your child take this medication at home? YES ☐ NO ☐ What Time: ____________ Only as needed ☐

Instructions/Indications for use: ____

Medication	Dose	Route	Time or Freq.	Daily or As Needed	Start Date	Stop Date

I request and authorize Lewisville ISD to administer the above medication(s) as prescribed. I understand that the school administrator may designate any qualified employee to administer this medication. I authorize the school registered nurse and the prescribing physician to confidentially discuss or clarify this medication order, and to discuss the student's response to the medication as required by law (Nurse Practice and Medical Practice Acts of Texas). If the consent for the nurse and the doctor to consult regarding this medication order is not granted or is revoked, it may not be possible for school personnel to administer the prescribed medications. ***This form is valid for one school year.***

Parent Initials ________ Unused medications not picked up at the end of the school year or within five days of being discontinued will be disposed of properly.

Parent Initials ________ **SECONDARY ONLY** - I GIVE permission for my child to transport medication to & from school.

Parent/Guardian Signature ________________________________ Printed Name ________________________________

Day Phone Number ______________________ Email __________________________________ Date ___/_____/_____

Physician signature is required under the following conditions:

- Over the counter medications not on the district approved list.
- Over the counter medications on the district approved list given more than 5 school days.
- Prescription label does not match the parent request or is missing the above required information.
- Medication samples or off-label prescription requests.

Physician Signature* ____________________________________ Print Name________________________________

*Physician must be licensed to practice in Texas. Temporary (2 months) orders for out of state US Physicians are acceptable for transferring students.

Date_______________ Office Number ___________________________ Fax Number ___________________________

Med Expires: ______/_______ Weight (if needed): ___________ kg Nurse's Notes: ____

Revised 7/2024