Wimberley ISD
Excellence. Innovation. Service.

# Request for Medication Administration

**Student:** _____ **DOB:** _____ **Grade:** _____

**Medications taken at home:** _____

**List any food or drug allergies:** _____

## PRESCRIPTION MEDICATION

**Medication:** _____ **Dose:** _____

**Take medication:** ☐ **by mouth** ☐ **via inhaler** ☐ **topical (cream)** ☐ **injection** ☐ **other** _____

**Condition for which medication is given:** _____

**To be given:** ☐ **Entire School Year - or -** ☐ **The following dates:** ____/____/____ **to:** ____/____/____

**When:** ☐ **Routinely at the following times:** _____ **- or -** ☐ **As Needed**

**Special considerations/side effects:** _____

**For Daily Medications:** ☐ **Yes, please administer daily medications on field trips**
☐ **No, please do not send daily medications on field trips**

## OVER-THE-COUNTER MEDICATION (TO BE GIVEN AS NEEDED)

**Medication:** _____ **Dose:** _____

**Take medication:** ☐ **by mouth** ☐ **topical (cream )**☐ **other** _____

**Condition for which medication is given:** _____

**Must be signed by a physician for any of these reasons:**

☐ prescription given more than 10 school days (daily medication)
☐ over-the-counter medications given more than 5 consecutive days
☐ over-the-counter medication to be given at higher than labeled dose

**Parent/Guardian:** I give permission for district personnel to administer medication to my child in accordance with Texas Education Agency and District policies. I authorize the physician named below to release information regarding medication(s) my child will take during school hours, to Wimberley ISD Student Health Services, and for the school nurse to exchange information with the physician regarding medication and health related issues. I will notify the school immediately if the health status of my child changes, we change physicians, or the medication is changed or canceled. I understand that school district personnel will protect my child by not administering the medication if this form is not complete or the prescribed medication is not provided.

Signature: _____ Date: _____
Printed Name _____ Relationship to Student: _____

**Physician Authorization:** I request that the student receive this medication during the school day as instructed above.***Please be sure to provide action plans for seizures, asthma, and severe allergies.***

Signature: _____ Date: _____
Printed Name: _____ Phone #: _____