Bullard Independent School District

Parent/Physician Request for
Administration of Medication by School Personnel

One form per medication

Medication may be administered by school personnel as follows:

1. When such treatment cannot be accomplished except during school hours
2. On receipt of this completed form along with the medication
3. Prescribed by a physician/dentist and in the original container with the pharmacy label—please request the pharmacist to dispense two labeled bottles of medication---one for home and one for school

Date of Request: _____ Teacher: _____

Name: _____ DOB: _____

Condition for which the medication/procedure is prescribed_____

Medication:_____ Is this a controlled drug ____Yes ____ No

Dosage: _____ Method of administration: _____

Time of administration: _____ If PRN, for what symptoms_____

Is this the initial dose of a new medication that has not been been administered at home? ____Yes ____No

Duration (dates) of administration: From: _____ to _____ (limit 1 school year)

Special instructions / precautions / side effects of this medication for your child?_____

_____

Physician's Name: _____ Phone:_____

Physician Signature: _____

My signature below indicates that I request that BISD staff administer the medication specified above to my child, and I am giving permission for BISD staff to contact the physician for additional information, if needed. I also give my permission for information regarding this medication to be shared with school personnel on a need-to-know basis.

I understand that parents are to pick-up all medications by 3:00 on the last day of classes and that all medications remaining after that time will be discarded.

Parent/Guardian Signature:_____ Phone: _____

E-mail:_____

FOR OFFICE USE ONLY

DATE	#PILLS	Counter Signature	Witness Signature	DATE	#PILLS	Counter Signature	Witness Signature