VYSEHRAD INDEPENDENT SCHOOL DISTRICT

Medication Administration Request/Solicitud de Administración de Medicamentos

When it is necessary for your child to receive medication during the school day:

- Parents/guardians must provide all medications and sign the Medication Administration Request form.
- All medication must be in the original container, clearly labeled with the student's name, the dosage, and directions for administration. Parents should request pharmacist provide a container to be used at school with the dosage amount and time required for the medication to be given at school. Over the counter doses must not exceed the recommended doses and directions of the bottle unless accompanied by a physician's order.
- The Medication Administration Request form must be completed each year and when there are any changes to the original request. A separate form must be completed for each medication.
- Only FDA approved pharmaceuticals (prescription and non-prescriptions) manufactured within the United States will be administered. Homeopathic preparations and allergy injections will not be accepted.
- A written physician's request is required for any medication administered longer than ten days.
- Sample medications from a physician must have written instructions from the physician.
- *In the interest of safety for all students, medications must be transported to or from school by a parent/guardian.* Medication counts will be performed on all controlled (e.g. schedule II) medications.
- At the end of the school year, all medication that has not been picked up by a parent/guardian will be destroyed.

STUDENT:______________________________ DOB:__________ DATE:__________

ALLERGIES:________________ TEACHER:______________________ GRADE:________

MEDICATION:______________________________ DOSE:__________ ROUTE:__________

TIME to be administered:______________ DATES to be administered______________

CONDITION for which medication is required:______________________________

PHYSICIAN'S PRINTED NAME: ______________________ PHONE:______________
FAX:______________
PHYSICIAN'S SIGNATURE: ______________________________
Any special instructions: ______________________________

My signature below, as the student's parent/guardian, indicates that I request that VISD staff administer the medication specified above to my child. The medication is furnished by me and is in its original container and the container is properly labeled. I am also giving my permission for VISD staff to contact the physician for additional information, if needed.

PARENT/GUARDIAN______________________________
PHONE:______________________________ DATE:______________

Medication Administration

Staff Name	Initials

Medication Received	Quantity	Received By	Parent Signature	Date

Disposition: