

Request and Consent for Administration of Prescription Medication

Name:		I.D.#	D.O.B	Teacher:		
Diagnosis:		AL	LERGIES:			
Campus				Grade		
We/I,		and		,the undersigned parent(s)/guardian(s) La Joya Independent School District, its agents,		
of		hereby requ	est and consent for La.	Joya Independ	ent School District, its agen	ts,
servants or employees	to administer the p	rescription medication(s) indicated below to m	y/our child:		
Medication	Dosage	Time		Amount	Dispensing Pharmacis	
I appoint		, a person	who is 18 years of age	or older to pic	k up the medication(s) at sc	hool
on my/our behalf, and	I authorize La Joya	I.S.D. to release the m	edication(s) to		<u>·</u>	
I further agree to abide	e by the following r	rules:				
1. I will persona	ally bring the medic	cation to the school nurs	e or send it with the per	son I have an	pointed herein above.	
		any medication deliver				
		y labeled and in the orig		it is placed by	the dispensing Texas	
pharmacist, o	therwise the school	l nurse will not accept it	<u>t.</u>			
		cation at home after sch		gnated adult m	ust pick up the medication a	t the
		not be sent home with t				
the school da	y. <u>Medication will</u>	not be sent nome with t	nie ciniu.			
		must be filled out and so or each time there are ch				
	ng currently admin		langes in the dosage and	J/OI tillie OI al	ıy	
		be required for all pro 's office for longer tha		nd for any Ov	er The Counter medication	1
Which whi b	e kept in the nurse	s office for longer tha	iii 10 days.			
Parent/Guardia	ın Signature	Date	Physician	's Name	Date	
Phone Number(s)			Physician'	Physician's Telephone Number		