**Request and Consent for Administration of Prescription Medication**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_Teacher:\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Campus Grade

We/I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,the undersigned parent(s)/guardian(s) of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby request and consent for La Joya Independent School District, its agents, servants or employees to administer the prescription medication(s) indicated below to my/our child:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Dosage | Time | Amount | Dispensing Pharmacist |
|  |  |  |  |  |
|  |  |  |  |  |

I appoint\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a person who is 18 years of age or older to pick up the medication(s) at school on my/our behalf, and I authorize La Joya I.S.D. to release the medication(s) to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I further agree to abide by the following rules:

1. I will personally bring the medication to the school nurse or send it with the person I have appointed herein above.

The school nurse will not accept any medication delivered to school by my child.

1. The medication must be properly labeled and in the original container in which it is placed by the dispensing Texas pharmacist, otherwise the school nurse will not accept it.
2. If I need to administer the medication at home after school hours, I or the designated adult must pick up the medication at the school nurse’s office no later than 30 minutes before the end of

the school day. Medication will not be sent home with the child.

4. A new request and consent form must be filled out and signed by the parent/guardian each time a new

medication is to be administered or each time there are changes in the dosage and/or time of any

medication being currently administered.

1. **The physician’s signature will be required for all prescribed medication and for any Over The Counter medication which will be kept in the nurse’s office for longer than 10 days.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date Physician’s Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number(s) Physician’s Telephone Number