TYLER INDEPENDENT SCHOOL DISTRICT

HEALTH SERVICES

PARENT REQUEST FOR SELF-ADMINISTRATION OF MEDICATION BY STUDENT

Student_____Grade_____

Date_____School_____

I request that my child, named above, be allowed to keep the following medication with him/her at all times as requested by his/her physician.

***Medication*_____**

I understand that self-administration requires responsible behavior. I acknowledge that sharing the medication with another person, leaving the medication where another person has access to the medication, or improper disposal of supplies will result in disciplinary action and the prescribed medication will then be kept in the clinic to be administered by school personnel.

I verify that my child is knowledgeable in when and how to administer the above medication.

I will instruct my child to notify the school nurse if he/she must administer the above medication during the school day.

I give my permission for the school nurse to contact the prescribing physician to discuss medication or special instructions. I also give my permission for information regarding this medication and special instructions to be shared by the school nurse with school personnel on a need-to-know basis.

Signature of Parent_____Parent phone_____

Signature of Student_____Home phone_____

PHYSICIAN REQUEST FOR SELF-ADMINISTRATION OF MEDICATION BY STUDENT

The above named student should be allowed to carry the medication prescribed below, on his/her person at all times. I verify that this student has been instructed in when, why and how to administer this medication and that the student has demonstrated that he/she can properly administer the medication without supervision.

Medication:_____Dosage and Frequency_____

Date of Request:_____ Date of Termination_____

Reason to Administer/Special instructions:_____

Physicians Signature_____Phone number_____