Wall ISD Medication Administration Form

I request that my child_____be given the following
Medication at school. I agree to comply with school policy regarding the administration of medication and understand that school personnel have the right to refuse to give medication at school if the medication policy is not followed.
Use this form only of you will be sending medication to be kept at school. **Wall ISD personnel do not keep medication on hand (Tylenol, Ibuprofen, Etc.) to be given to students. Medication must be sent from home in the original container according to medication policy.**

Name of Medication: _____
Dose to be given: _____
To be given Daily or "as needed" (circle one)
For Daily medication TIME to be given: _____
How often medication "as needed" can be given: _____
Reason for medication: _____
How long medication should be continued. _____
Other Instructions: _____
Parent Signature: _____
Phone Number: _____ Date: _____

Date	Time Given	Initials	Date	Time Given	Initials

Nurse Signature:_____