HIGHLAND PARK INDEPENDENT SCHOOL DISTRICT

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Parent Request for Administration of Medication by School Personnel

Date of Request: _____ School: _____ School Year: _____

Student: _____ Grade/Teacher: _____

D.O.B._____ Parent _____ Phone: _____

Physician's Name: _____ Phone: _____

Medication: _____ Exp. Date: _____ Dosage:_____

Route: _____Time(s) to be given: _____ Duration: ❑ All Year _____ Days ❑ As needed

Condition for which medication is required:_____

Has your child take this medication before? ❑ YES ❑ NO

Medication Allergies: ❑ YES ❑ NO If yes, please list:_____

Special Instructions/Precautions/Side Effects:_____

_____

IMPORTANT NOTE:

Medication must be in its **original, properly labeled** container and up-to-date by law. Medications scheduled for three (3) times a day require a physician's written authorization stating that it must be given during school hours. Medications must be picked up at the end of the school year or they will be discarded.

The school does not provide over-the-counter medications such as Tylenol, Advil, or cough syrup, etc. *These need to be supplied annually by the parent or guardian.*

I request that HPISD Staff administer the medication to my child and grant permission for the School Nurse to contact the prescribing physician, as needed. I release this individual and Highland Park Independent School District from liability due to any allergic or adverse reaction to this drug.

Parent Signature: _____ Date: _____