Student's Last Name | First Name | Drug Allergies | Grade | Teacher

PLANO INDEPENDENT SCHOOL DISTRICT
Medication Request Form

Please follow the guidelines below when bringing medication to school:

1. For student safety, **all medications should be brought to the clinic by the parent**. Medications **are not** provided by the school.
2. **All medication** must be in its original, properly labeled container with a written request signed by the parent/guardian.
3. Only medication that cannot be given at home will be given at school.
4. Only a 30-day supply of medication will be accepted at a time. **(Amount received by nurse________)**
5. **Medication that has expired or is not picked up by the parent will be destroyed**.
6. Authorized district employees may administer medication in the absence of the nurse.
7. Aspirin or products containing aspirin will not be given without a physician order.

Medication__________________________________ Dosage/Time/Days to Give________________________________

Prescription Number___________________ Will this be the first dose of a new medication for your child? ☐ YES ☐ NO

Expiration Date_________ (*Responsibility of parent*) What is the condition for which this medication is required?____________________

Any special instructions/precautions/side effects of this medication for your child?________________________________

____

Parent Signature ____________________________________ Date________________ Phone Number ______________________

Physician's Name ____ Phone Number ______________________

A physician's signature is required to administer over-the-counter medication for more than 10 consecutive days.

Physician's Signature ____ Date _______________________

Rev.3/14/08

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