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 medication should be brought to the clinic by the parent.** **Controlled substances must 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.
8. Nonprescription, homeopathic medication, dietary supplements and herbal supplements will only be given in accordance with Plano ISD Board Policies FFAC(LEGAL) and FFAC(LOCAL).

Medication ______________________________ Prescription Number ______________________

Dosage ______________ Time ____________________ Days to Give ______________________

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?

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By my signature below, I affirm that it is impossible to schedule the above-mentioned medication at a time other than school hours. I request that this medication be given by a school employee. I acknowledge that I will not hold the Plano ISD, Board of Trustees, and/or District employees for damages or injuries resulting from administration of this medication (prescription/nonprescription/ homeopathic/over-the-counter), dietary supplement and/or herbal supplement.

I consent to the release of the medical information contained on this form to school officials who have a legitimate educational interest in the information, according to PISD Board Policy and the Family Education Rights and Privacy Act. I give permission for the release of confidential information regarding my child's specific health problems to third parties, other than school officials, including the physician and/or physician's office identified below, as required to facilitate medical care and/or treatment of my child.

Parent Signature ________________ Date ____________ Phone Number ________________

Email address ____

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 ____________________

1/25/10