

_____,
LAST NAME FIRST NAME GRADE DRUG ALLERGIES

**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.

Medication _____ Dosage/Time/Days to Give _____

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

Prescription Expiration Date _____ 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 keep or administer over-the-counter medication for more than 10 days from the original parent request.

Physician's Signature _____ Date _____

Rev. 2/8/2007

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