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 for the District's designee, including District medical professionals, to share/obtain my student's health related information with the medical health professional or health care provider identified below, in order to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other PISD form requesting school health care services. I understand that school related health services will not be provided to my student without my required consent, as outlined herein.

Parent Signature ______________ Date __________ Phone Number ______________

Email address ____

Student's Health Care Provider ______________________ Phone Number ______________

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

Physician's Signature ______________________ Date ______________

8/8/11