2017-2018

HEALTH SERVICES
Richardson Independent School District

Parent/Physician Request for Administration of Medication by School Personnel

Date of Request: _____ **School:** _____ **Teacher/Grade:** _____

Student's Name: _____ **Birth date:** _____/_____/_____

Medication: _____ **Exp. Date**_____ **Dosage:** _____

Route of administration: ☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ injection (circle: IM SQ IV) ☐ rectal ☐ GT/JT

Time to be Administered: _____ **Dates to be Administered:** _____

Condition for which medication is required: _____

Has your child ever taken this medication before? YES NO

Medication Allergies: ☐ No Known Medication Allergies ☐ Allergic to: _____

Special Instructions or known Side Effects of medication on your child: _____

_____

Please indicate how you would like the medication to be returned home:

☐ Send home in my child's backpack* ☐ Parent/Guardian will pick up med from clinic ☐ Do not return med, please discard any remaining doses

**Controlled substances (such as Ritalin, amphetamine salts, etc.) must be transported by a parent/guardian and will not be released to students.*

The district will take reasonable measures to store medication at ambient room temperatures unless refrigeration is required. Parents must take home medications during school breaks to avoid exposing medications to extreme heat or cold.

My signature below indicates that I request that RISD staff administer the medication specified above to my child, and I am giving permission for RISD staff to contact the physician for additional information, if needed. I understand that for prescription medications, only a 30-day supply will be accepted at a time.

Parent/Guardian Signature: _____ **Email:** _____

Parent's Primary Phone: (_____)_____-_____ **Alternate Phone:** (_____)_____-_____

Physician's Name: _____ **Phone:** (_____)_____-_____

**A physician's signature is required to administer over-the-counter medications for more than 10 consecutive school days from the date of the original request. Medications with a printed pharmacy label for the student do NOT require the physician's signature below.*

***Physician's Signature:** _____

FOR OFFICE USE ONLY!

☐ Entered in Focus
☐ Teacher Notified ___/___

Prescription Medication Count:

Date	# Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials

Comments (Indicated by * on back of form):

Date	Comments	Date	Comments

Date	RN Review

Medication returned to: Parent / Student _____ Date _____
Parent/Student Signature

STUDENT NAME: _____ **MEDICATION:** _____

DOSAGE:_____ **TIME:**_____

DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY
1												1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
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27												27
28												28
29												29
30												30
31												31
DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY

CHARTING CODES

A	DC	FT	H	OOM	R	*
Absent	Discontinued	Field Trip	Hold	Out of Medication	REACH	Comments

* Indicates Comments on front of form