Holland Independent School District

Physician's Request for Administration of Medication by School Personnel

Date: _______________ **Name of Student**: ____ **DOB**: ____________

Known Allergies: ____

Name of Medication____

Medication Dose Amount and Route: ____

Time(s) to be given at school____

Special Instructions:____

Condition for which the medication is prescribed:____

Medication Side Effects: ____

Physician's Printed Name______________________________ **Physician's Signature**_____________________________

Physician's Telephone_________________________________ **Physician's Fax**__________________________________

Asthma Medication

All Inhalers Must Have the Label on the Canister or Brought To School in the Labeled Prescription Box.

Student may carry inhaler on person and self-administer ☐ YES ☐ Physician Initials

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Parent Permission

I request that designated **District** personnel administer the medication listed above to my child according to the physician instructions. I agree to furnish and replenish an adequate amount of medication in the ***original container*** for the purpose of administration during the school day and/or school related activity. I understand that medication will not be administered without this completed form and medication furnished as required.

I also give permission for the school to contact the above health care provider about the administration of this medication.

******Please Note: Medication should be delivered to the nurses office by a parent or legal guardian.******

Medication remaining at end of school year will be: (circle one) 1) **Disposed of by the school** 2) **Picked up by Parent/Guardian**

On early dismissal day I want my child to receive scheduled medication: (circle one) 1) **At School** 2) **At Home**

I give permission for this form to be faxed to my child's school nurse. ☐ **YES** **Fax: 254-657-2636**

Parent /Guardian Printed Name _________________________ **Parent/Guardian Signature**________________________

Phone: Cell___________________ **Work**___________________________ **Home**________________________________

Email Address____

*Nurse office use: **Orders received**________________ **Medication Received**__________________ **Nurse Initial**________

Date **Date**