MALAKOFF ISD

PHYSICIAN/PARENT REQUEST FOR ADMINISTRATION OF MEDICINE OR SPECIAL PROCEDURE BY SCHOOL PERSONNEL

Special health care procedures and medications may be prescribed for administration by school personnel as follows:

1. When such treatment cannot otherwise be accomplished.
2. On receipt of this completed form along with prescription and/or special equipment items.
3. Please request pharmacist to dispense two labeled bottles of medication: one for home and one for school.

Prescribed in-school medication/treatment may be administered by a non-health professional designate of the principal or school nurse.

1. Name of pupil_____ Birth Date _____
2. Address_____ School_____
3. Condition for which prescribed treatment is required:_____
4. Specific medication or procedure:_____
5. Dosage and method of administration:_____
6. Precautions, unfavorable reactions:_____
7. Disposition of pupil following administration or procedure:_____rest, _____home, _____hospital, _____doctor's office, _____return to class
8. Date of Request_____/ Date of Termination _____
9. _____/_____
   Physician's Name (printed) Signature
   _____/_____
   Physician's Address Telephone Number

I, the undersigned, the parent/guardian of _____
Student's Name

request the above medication or procedure be administered to my child.

_____/_____ Telephone _____/_____
Name Relationship Home Other

HB 1688 allows students to self-administer asthma medications while at school or school-related events with permission from parents and physicians.

I have instructed _____ in the proper way to use his/her medications.

It is my professional opinion that _____ should be allowed to carry and self-administer the following medications while on school property or at school-related events:

Name of Medication:_____ Dosage:_____

Purpose:_____ When to use:_____

Date of Request:_____ Date of Termination:_____

_____/_____

Physician's Name (printed) Physician's Signature

_____/_____

Physician's Address Telephone Number

I agree with the recommendations of my child's physician as noted and have informed my child that he/she may carry his/her asthma medications while at school or school related events.

_____/_____

Parent/Guardian Signature Date