BEEVILLE
INDEPENDENT SCHOOL DISTRICT

Parent Request for School Assistance in Administering Medication

***Every effort should be made to avoid administering medications while at school. Except for emergency medications such as asthma inhalers, Epi-Pens, Diastat, ONCE DAILY, and TWICE DAILY MEDICATIONS MUST BE GIVEN AT HOME.**

1. A complete ***Parent Request for School Assistance in Administering Medication*** form must be turned in to the school nurse or principal.
2. School personnel cannot administer medications if there is any missing information on the form. **Please complete entirely.**
3. All medications requiring special instructions, or to be administered longer than 10 days, MUST have a doctor's order with the prescribing doctors signature and office number (contact your school nurse for questions).
4. Prescription medications must be in the pharmacy container, with original prescription label including: student's name, the name of the drug, instructions for taking the medication, the prescription number, and name of prescribing physician when applicable.
5. **ALL MEDICINES MUST BE IN THE ORIGINAL CONTAINER (you may ask your pharmacist for an extra "SCHOOL SUPPLY" container).**
6. A responsible adult must bring only the amount of medication required for school doses to the school and refill as needed. Medications cannot be stored at school, and must be picked up by a responsible adult when no longer needed.
7. **Over the counter medications and topical ointments** must be in the original container, not expired, **and can only be given according to the manufacturer recommendations for a maximum of 10 days, unless specific, signed Doctor's orders are written.** See your school nurse if you have any questions.
8. The first dose of any medication must be administered by parent or guardian.

----------**PARENTS- Please fill out the following information completely and sign for authorization**----------

It is against school policy and student code of conduct for students to carry medications on campus without a doctor's order on file. Do not send medication alone with your child. ********ONLY ONE MEDICATION PER SHEET.********

Complete Medication order and instructions (must match prescription order on container or be within recommended manufacturer dosing directions)	School Dose TIME *(doctor's order needed if to be given longer than 10days)	Start Date and Stop Date
		Start_____ Stop_____

_____ _____ _____

Physician's Signature **Office#** **Date:**

I, the undersigned parent or guardian of _____ **DOB:** _____ , request the assistance of the Beeville Independent School District in administering the medication, as written above, to my child. I request that medication for my child be kept under the control of the school nurse, principal, office staff, or homeroom teacher, and that it be made available to my child to be given as ordered.

I realize the school cannot, in any way, accept responsibility for the administration of medication to the above named student nor for any condition resulting from the child's failure to procure such medication.

The child and I accept full responsibility for such medication and for the administration of the medication to the child.

Please answer the following questions:

1. List of Food/Drug/Environmental Allergies: _____

2a. Has the first dose of this medication been given at home? ☐ **Yes** ☐ **No** **2b. Any noted Reactions** ☐ **No** ☐ **Yes, describe** ____

_____

3. List of all medications currently taken (include how often): _____

_____

4. Other health problems/diagnosis:_____

Printed Name and Phone Number: _____

Parent Signature: _____ Date: _____

Student Name:_____ Campus: _____ Room number: _____ Grade: _____