Como-Pickton CISD
Request for Administration of Medicine or Special Procedure
By School Personnel

Student: _____ Date of Birth_____

Grade: _____Teacher/Homeroom: _____

Date form received by the school_____

Name of Medicine: _____

Reason for Medicine: _____

Dosage and Schedule to be given at school: _____

Form of medication/ treatment:
Tablet___ Liquid___ Inhaler___ Injection___ Nebulizer___ Other___

Restrictions and / or side effects: Yes or No. If yes, please describe: _____

_____

Start _____date form received Stop _____end of school year

Other date: _____ Other duration:____ For emergency episodes only:____

Date: _____ Physician's Signature: _____

Physician's Name_____

Address_____

Phone Number: _____ Fax Number: _____

I give permission for (name of child) _____
to receive the above medication at school according to standard school policy.

Parent/Guardian Signature: _____Date: _____

Relationship: _____

# MEDICATION LOG

Student

Med/Dose

Instructions

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Signatures