McKinney Independent School District
School Health Services

Valid for school year _____

Prescription Medication Administration

PARENT 'S REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION TO A STUDENT

All prescription medication MUST be in the original container with a pharmacy prescription label. No more than **one month's** supply of medication, in a prescription labeled bottle, shall be brought to the clinic at one time. All prescription medication given more than 10 days will **REQUIRE** a physician's signature.
Note: We are unable to store any medications at the school during the summer and will dispose of all medicine left after the last day of school.

Name of Student:_____Date of Request: _____

Address:_____Birth Date: _____

School: _____ Home Phone: _____

Teacher:_____Grade: _____

Name of medication:_____Expiration date:_____

Condition for which medication is to be given: _____

Amount to be given:_____Time to be given: _____

Special instructions: _____

Date medicine is to be discontinued: _____

It is impossible to schedule the above-mentioned medication at a time other than school hours. I request that this medication be given by a school employee. I understand that the School District, Board of Trustees, and District employees shall not be held responsible for damages or injuries resulting from administration of this medication. I understand that if at any time the supervising adult believes my child's life is in danger, Emergency Medical Services (911) will be activated, and I agree that my insurance carrier or I will assume the responsibility for all costs incurred as a result.
I consent to the release of the medical information contained on this form to school officials who have a legitimate educational interest in the information, according to MISD Board Policy and the Family Education Right s and Privacy Act. I give permission for the release of confidential information regarding my child's specific health problems to third parties, other than school officials, as required to facilitate medical care and/or treatment of my child. I authorize the nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

_____ _____
Signature of Parent or Guardian *Daytime Phone Number*

Please have physician or dentist complete this portion if medication is to be given for longer than **10 days**. Statement of physician or dentist: It is necessary that the above-mentioned medication be given as prescribed until _____.

_____ _____ _____
Printed Name of Physician Phone Number Signature of Physician