Parent Request for Administration of Medication by School Personnel

CONROE INDEPENDENT SCHOOL DISTRICT
Health Services

Place Student Photo Here

CONFIDENTIAL

SCHOOL YEAR _____

Parent/Guardian email _____

Parent/Guardian email _____

Date Entered in eSchool _____ Nurse Initials _____

Student Name _____ **ID#** _____

Student's Date of Birth _____ **Teacher** _____ **Grade** _____

As the Parent / Guardian of the above named child, I give my permission for him / her to be given the medication as described below by whomever the principal designates. I understand medication will be handled according to recommended Conroe ISD Policy and Procedure, TEA recommendations and FDA Guidelines.

Printed Name of Parent/Guardian _____

Signature _____ **Relationship to Student** (Ex. Mom, Step Parent, Etc.) _____

Daytime Phone Number(s) _____ **Today's Date** _____

Name of Medication		**Medication Strength**
Route of Administration: ☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ injection: (☐ IM ☐ SQ ☐ IV) ☐ rectal		
Dosage	**Reason for Taking**	
Give Daily **Time(s):**	**OR**	**Give PRN/As Needed** **Frequency:**
Medication Start Date	**Medication End Date**	***Medication Expiration Date***
Special Instructions		
Other Medication(s) Student is Taking		

IF THERE IS A CHANGE IN DOSAGE, AMOUNT, OR TIME, FILL OUT A NEW MEDICATION PERMISSION FORM.

MEDICATION CHECK-IN			PRINT FORM AND MANUALLY SIGN
Date Received	**Amount/Number**	**Clinic Staff Signature**	**Parent/Guardian Signature**
Original			
REFILL(S)			
#1			
#2			
#3			
#4			
#5			
#6			
#7			

Physician Name _____ Physician Phone Number _____

Physician Signature _____ Date _____

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Med. Pick-Up Date_____ **By** _____ **Relationship** _____ **Count** _____ **Staff Initials** _____

CONROE INDEPENDENT SCHOOL DISTRICT
Health Services

Parent Request for Administration of Medication by School Personnel

2022-2023

CONFIDENTIAL

Student Name _____ **DOB** _____ **ID#** _____

Name of Medication _____ **Grade** _____

AUGUST					
Date	M	T	W	TH	F
1-5					
8-11					
15-19					
22-26					
29-31					

SEPTEMBER					
Date	M	T	W	TH	F
1-2					
5-9					
12-16					
19-23					
26-30					

OCTOBER					
Date	M	T	W	TH	F
3-7					
10-14					
17-21					
24-28					
31					

NOVEMBER					
Date	M	T	W	TH	F
1-4					
7-11					
14-17					
21-25					
28-30					

DECEMBER					
Date	M	T	W	TH	F
1-2					
5-9					
12-16					
19-23					
26-30					

JANUARY					
Date	M	T	W	TH	F
2-6					
9-13					
16-20					
23-27					
30-31					

FEBRUARY					
Date	M	T	W	TH	F
1-3					
6-10					
13-17					
20-24					
27-28					

MARCH					
Date	M	T	W	TH	F
1-3					
6-10					
13-17					
20-24					
27-31					

APRIL					
Date	M	T	W	TH	F
3-7					
10-14					
17-21					
24-28					
-					

MAY					
Date	M	T	W	TH	F
1-5					
8-12					
15-19					
22-26					
29-31					

JUNE					
Date	M	T	W	TH	F
1-2					
5-9					
12-16					
19-23					
26-30					

SIGNATURES
Name/Initials _____
Name/Initials _____
Name/Initials _____
Name/Initials _____
Name/Initials _____

Comments/Notes: