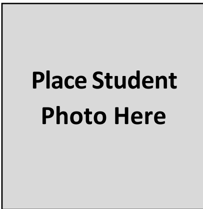
Parent Request for Administration of Medication by School Personnel

CONROE INDEPENDENT SCHOOL DISTRICT
Health Services



CONFIDENTIAL

SCHOOL YEAR ________________

Teacher________________________**GR**_____________

Parent/Guardian email ____________________________

Date Entered in eSchoolPlus _________ **Nurse Init.**_______

Student Name____**Student ID**____________________**DOB**___________________________

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 ____**Daytime Phone Number(s)**______________________________

Signature ____________________________________**Relationship to Student** (Ex. Mom, Step Parent, Etc.) ________________**Today's Date** ___________________

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

Date Received	Time In	Amount/ Number	Pill Description (Match to Label)	Medication/ RX Expiration	Clinic Staff Signature	Parent/Guardian Signature	Reconciled Date	Nurse Verified
Original								
REFILL(S)								
#1								
#2								
#3								
#4								
#5								
#6								

Physician Name ________________________________ Physician Signature ___________________________________Physician Phone Number__________________Date_________

****

Med. Pick-Up Date__________________**Time**__________ **By /Sign**__________________________________**Relationship**____________________________**Count** _________ **Staff Initials**___________

Parent Request for Administration of Medication by School Personnel

CONROE
INDEPENDENT SCHOOL DISTRICT
Health Services

2023-2024

CONFIDENTIAL

Student Name ______________________ **DOB** __________ **ID#** __________

Name of Medication ______________________ **Grade** __________

AUGUST					
Date	M	T	W	TH	F
1-4					
7-11					
14-18					
21-25					
28-31					

SEPTEMBER					
Date	M	T	W	TH	F
1					
4-8					
11-15					
18-22					
25-29					

OCTOBER					
Date	M	T	W	TH	F
3-6					
9-13					
16-20					
23-27					
30-31					

NOVEMBER					
Date	M	T	W	TH	F
1-3					
6-10					
13-17					
20-24					
27-30					

DECEMBER					
Date	M	T	W	TH	F
1					
4-8					
11-15					
18-22					
25-29					

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

FEBRUARY					
Date	M	T	W	TH	F
1-2					
5-9					
12-16					
19-23					
26-29					

MARCH					
Date	M	T	W	TH	F
1					
4-8					
11-15					
18-22					
25-29					

APRIL					
Date	M	T	W	TH	F
1-5					
8-12					
15-19					
22-26					
29-30					

MAY					
Date	M	T	W	TH	F
1-3					
6-10					
13-17					
20-24					
29-31					

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

SIGNATURES

Name/Initials ______________

Name/Initials ______________

Name/Initials ______________

Name/Initials ______________

Name/Initials ______________

Comments/Notes: