Student's Last Name First Name Drug Allergies Grade Teacher

Azle Independent School District Medication Request Form

Please follow the guidelines below when bringing medication to school:

1. For student safety, **all medication must be brought to the clinic by the parent/guardian.** Medications **are not** provided by the school.
2. **All medication** must be in its original, properly labeled container with a written request signed by the parent/guardian.
3. **A physician's signature is required to administer over-the-counter medication for more than 10 doses during the school year.**
4. Only medication that cannot be given at home will be given at school.
5. A maximum of a 30-day supply of medication will be accepted at a time. **(Amount received by nurse_____.)**
6. **Medication that has expired or is not picked up by the parent will be destroyed.**
7. Authorized district employees may administer medication in the absence of the nurse.
8. Aspirin or products containing aspirin will not be given without a physician's order.
9. Nonprescription, homeopathic medication, dietary supplements, and herbal supplements will only be given in accordance with Azle ISD Board Policies FFAC(Legal) and FFAC(Local).
10. Azle ISD personnel will not administer narcotic pain medication to students.
11. Students that may require self-administration asthma or anaphylaxis medicine will need a physician's signature on this form.*
12. **Must be completed by the parent and/or physician:**

Medication _____ Prescription Number _____

Dosage _____ Time_____ Days to Give _____ Expiration Date _____

Will this be the first dose of a new medication for your child? ○ Yes ○ No

What is the condition for which this medication is required? _____

_____

Any special instructions/precautions/side effects of the medication for your child? _____

_____

I give permission for the prescribed medication or procedure to be administered to my child at school. I also give my permission for confidential and discreet use of the above information to meet my child's health and education needs at school.

_____ _____ _____

Parent Signature Date Phone Number

_____

Email Address

_____ _____

Student's Health Care Provider Phone Number

_____

*Physician's Signature *(required to administer over-the-counter medications for more than 10 school days from the date of the original request, and for students that will be self-administering medications)*

For Office Use Only - Medication Count							
Date	# Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials