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. 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 signature is required to administer over-the-counter medication for more than 10 consecutive days.*
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. Students that may require self-administration asthma or anaphylaxis medicine will need a physician’s signature on this form.*

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 effect 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 Date Phone Number

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

For Office Use Only - Medication Count

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<th># Pills</th>
<th>Counter’s Signature</th>
<th>Witness Initials</th>
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