tudent'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.** 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 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							
Date	# Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials