

**CONROE**INDEPENDENT SCHOOL DISTRICT
Health Services**Parent Request for Administration of Medication by School Personnel**Place Student
Photo Here**CONFIDENTIAL**

Date Entered in eSchool _____ Nurse Initials _____

Student Name _____ ID# _____

Student's Date of Birth _____ Teacher N/A 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: <input type="checkbox"/> by mouth <input type="checkbox"/> inhaled <input type="checkbox"/> topical <input type="checkbox"/> eye(s) <input type="checkbox"/> ear(s) <input type="checkbox"/> nasal <input type="checkbox"/> injection (circle: IM SQ IV) <input type="checkbox"/> 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			
CHANGES	Date	Change in Dose, Amount, or Time	Parent Signature
	Date	Change in Dose, Amount, or Time	Parent Signature
MEDICATION CHECK-IN			
Date Received	Amount/Number	Clinic Staff Signature	Parent/Guardian Signature
Original			
REFILL(S)			
#1			
#2			
#3			
#4			
#5			
#6			
#7			
#8			
#9			

Med. Pick-Up Date _____ By _____ Relationship _____ Count _____ Staff Initials _____