CONROE INDEPENDENT SCHOOL DISTRICT
Health Services

Parent Request for Administration of Medication by School Personnel

Place Student Photo Here

CONFIDENTIAL

FIELD TRIP ONLY

*** SECTION BELOW TO BE COMPLETED BY PARENT ***

Student Name _____ **ID#** _____

Student's Date of Birth _____ **Teacher/Sponsor**_____ **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** _____

***SECTION BELOW TO BE COMPLETED BY STAFF ***

Name of Medication				Medication Strength
Route of Administration: ☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ injection (circle: IM SQ IV) ☐ rectal				
Dosage	Reason for Taking			
DAILY MED	Daily Time(s):	OR	AS NEEDED	Give PRN/As Needed Frequency:
Medication Start Date/Time (Field Trip)	Medication End Date/Time (Field Trip)			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 TO BE COMPLETED BY STAFF & PARENT ***

Date Received	Amount/Number	Clinic Staff Signature	Parent/Guardian Signature
Original			x
REFILL(S)			
#1			
#2			
#3			
#4			
#5			
#6			

Med. Pick-Up Date_____ **By** _____ **Relationship** _____ **Count** _____ **Staff Initials** _____

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Student Name ______________________________ **DOB** ____________ **ID#** ______________

Name of Medication ______________________________________ **Grade** ___________

Date Given	Time Given	Notes	Given By: (Signature)