**KELLER INDEPENDENT SCHOOL DISTRICT**
**HEALTH SERVICES DEPARTMENT**
**REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL**

**Student's name: _____DOB: _____Grade: _____ Teacher: _____**

Only medications that are required to enable a student to stay in school may be administered at school. Medications ordered three times a day can be given before school, after school, and at bedtime.
Please speak to the school nurse if your child requires long-term medication, any health procedure, or monitoring.

Medication will be administered at school under the following conditions:

1. MEDICATION MUST BE IN ORIGINAL PROPERLY LABELED CONTAINER, dated for the current school year and brought to school by an adult. MEDICATION SENT IN BAGGIES OR UNLABELED CONTAINERS WILL NOT BE GIVEN.
2. Prescription medications will only be administered with a specific written request signed by at least one parent/guardian. Physicians must be licensed to practice medicine in the State of Texas. A current prescription label will serve as the physician's signature.
3. A trained unlicensed employee may administer the medication.
4. All medications must be kept in the clinic, except for students whose physician and parent furnishes the school with a written permit to carry an inhaler or epi-pen on their person.
5. FDA APPROVED OVER THE COUNTER MEDICINE REQUIRES PARENT/GUARDIAN WRITTEN PERMISSION AND MAY NOT BE GIVEN FOR MORE THAN 10 DAYS or 10 DOSES DURING A SCHOOL YEAR WITHOUT A DOCTOR'S WRITTEN ORDER.
6. Medication must be picked up by parent/guardian by the end of the school year. Otherwise, it will be destroyed.
7. The District can assume no responsibility for loss or negligent behavior when the student carries his/her conventional, alternative medication, or dietary supplement without the knowledge of the campus nurse.

| Start Date | Name of Medication/Amount Provided | Strength (i.e. 10 mg) | Dosage (i.e. 2 tabs or 1 tsp) | Time to be given |
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***Date/Time/Initials – Clinic Use Only***

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Staff signature/initials: _____ _____ _____ _____

**PARENT/GUARDIAN CONSENT:**

**I give my permission for the above medication to be given to my child at school or on school sponsored field trips, as applicable. I understand that the medication may be given by an authorized KISD employee. I consent to and authorize the healthcare provider to disclose health information to the school, and for the school to disclose the above information to those within the school district that have a need to know for legitimate educational purposes.**

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**Parent/Guardian Signature** **Contact #** **Date**

_____

**Physician's Signature** **Contact #** **Date**

Updated March 2020