

**MIDLOTHIAN INDEPENDENT SCHOOL DISTRICT**

**SCHOOL HEALTH SERVICES**

**PHYSICIAN/PARENT REQUEST FOR ADMINISTRATION OF MEDICATION OR SPECIAL PROCEDURE**

**\*\*Please Note:** Both physician and parent portions of this form must be completed before medication can be given or procedures accomplished with your child.

**PHYSICIAN:**

Special health care procedures and medications may be prescribed for administration by school personnel as follows:

1. When such treatment cannot otherwise be accomplished.
2. Upon receipt of this completed form along with medication and/or special equipment items.

MEDICATION #1: _____
DOSAGE: _____
TIME TO BE GIVEN: _____
Condition/Symptom requiring Treatment: _____
Precautions/Adverse Reactions: _____
Other Information: _____
Date of Request: _____
Date of Termination: _____

MEDICATION #2: _____
DOSAGE: _____
TIME TO BE GIVEN: _____
Condition/Symptom requiring Treatment: _____
Precautions/Adverse Reactions: _____
Other Information: _____
Date of Request: _____
Date of Termination: _____

\_\_\_\_\_  
**PHYSICIAN'S NAME (printed)**

\_\_\_\_\_  
**PHYSICIAN'S SIGNATURE**

Physician's Address: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

**PARENT/GUARDIAN:**

I, the undersigned, the parent/guardian of the student named below, request the above medication or procedure to be administered to my child. I will notify the nurse in writing of any medication or procedure changes. At the end of the school year, I consent that the above named student may bring home any remaining medication unless otherwise stated.

**Student's Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **School Year:** \_\_\_\_\_

\_\_\_\_\_  
**PARENT/GUARDIAN'S NAME (printed)**

\_\_\_\_\_  
**PARENT/GUARDIAN'S SIGNATURE**

Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

**\*\*\*If medication is to treat Asthma or anaphylaxis:**

**If the physician and the parent desire that the student possess and self administer the necessary medicine/device while on school property, the physician and the parent must agree and initial below. The student must also meet the following criteria:**

- 1) **The student has been taught proper technique to self administer prescription asthma and/or anaphylaxis medication, including the use of any device used to administer the medication.**
- 2) **The student has the necessary skill level to self administer the medication proven by return demonstration.**

**Physician's Initials:** \_\_\_\_\_ **Parent/Guardian's Initial's:** \_\_\_\_\_