HENRIETTA ISD

Department of School Health Services

Prescription Medication / Treatment Request

When it is necessary for your child to receive medication during the school day:

- Parents/guardians should deliver the medication/treatment supplies to the clinic or office along with the completed and signed medication/treatment form.
- Medication must be in a bottle from the pharmacy, properly labeled with the student's name, the physician, the medication name and quantity, administration directions with dosage and time and the date of this prescription's issue. *You may ask your pharmacist for a second, properly labeled bottle so you have one for home and one for school.*
- Medications sent in baggies or unlabeled containers, will not be given. Medication will not be accepted if the label has been altered by hand.
- The Prescription Medication Request must be completed each school year and when there are any changes to the original request including a medication and/or dose change. A separate form must be completed for each medication.
- Parents/guardians are strongly encouraged to pick up all medication immediately after it is discontinued. At the End Of The School Year, All Medication That Has Not Been Picked Up By The Parent/Guardian Will Be Destroyed.

PARENT

Student:_____ Birthdate:_____ Grade:_____

School:_____ Medication/Food Allergies: _____

My signature below indicates that I request HISD staff (may include trained Non-Medical personnel) to administer the medication specified below to my child, and I am giving permission for HISD staff to contact the physician for additional information, if needed. I consent to and authorize the health care provider to disclose health information to the school, and for the school to disclose information to those within the school district who have a need to know for legitimate educational purposes.

Parent Signature:_____ Email Address: _____

Phone (Home):_____ (Work):_____ (Cell): _____

PHYSICIAN

Medication/Treatment:_____

Dosage:_____ Route:_____ Time:_____

Special Instructions/Precautions/Side Effects of this medication: _____

Condition for which medication is required:_____ Termination Date of Medication: _____

Physician's Signature:_____ Date: _____

Phone:_____ Fax:_____

IF THE ORDERED MEDICATION IS AN INHALER OR AN EPI PEN, PLEASE ANSWER THE FOLLOWING:

1. May this student carry an INHALER / EPI-PEN on self during the day? ❒ Yes ❒ No
2. Has the student been instructed in the use of the INHALER / EPI PEN? ❒ Yes ❒ No
3. Is the student able to self-administer the INHALER / EPI PEN? ❒ Yes ❒ No

Medication/Procedure Order Reviewed by Supervising RN:_____ Date: _____