Please return this form to:
Stockdale ISD
Deirdre Hastings, R.N., School Nurse
Elementary Office: 830-996-1612 x1059 Fax: 830-996-3236
Jr. High & High School Office: 830-996-3153 x 1045 Fax: 830-996-3055

Request for Administration of Medication at School

Student's name (print): _____

Date of birth: _____ Grade: _____ Teacher/Classroom:_____

Physician information

Name: _____

Address: _____

Phone number: _____

Physician's signature: _____ Date: _____

Instructions (name of medicine, dose, route, and time to be given at school)

Doctor's order: _____

_____

_____

Type of medication ☐ Prescription ☐ Non-prescription

Reason for medication: _____

Form of medication/treatment *(check appropriate box)*

☐ Tablet/capsule ☐ Liquid ☐ Inhale ☐ Injection ☐ Nebulizer
☐ Spray/Cream or lotion (e.g., insect repellant) ☐ Other: _____

Start: ☐ Date form received ☐ Other date: _____

Stop: ☐ End of school year ☐ Other date: _____

Restrictions and/or important side effects

- ☐ None anticipated
- ☐ Yes, describe: _____

Special storage instructions

- ☐ None ☐ Refrigerate
- ☐ Other (please describe): _____

[To be completed by the parent or guardian]

I give permission for _____ *(student's name)* to receive the above medication at school in accordance with District policy. [See FFAC]

Parent's or Guardian's Signature: _____ **Date:** _____

This form was developed using resources from the American Academy of Pediatrics and Texas Department of State Health Services.

Date form was received by school: _____