COMANCHE
INDEPENDENT SCHOOL DISTRICT

Request for Medication Administration

Student: _____ DOB _____ Grade: _____ Campus: _____

Medication: _____ Dose: _____

Take medication: □ by mouth □ via inhaler □ topical (cream) □ injection □ other _____

Condition for which medication is given: _____

To be given: □ Entire School Year - or - □ The following dates: ___ /___ /____ to: ___ /___ /____

When: □ Routinely at the following times: _____ - or - □ As needed

Special considerations/side effects: _____

For Daily Medications: □ Yes, please administer daily medication on field trips
□ No, please do not send daily medication on field trips

Other medications taken at home: _____
List any food or drug allergies: _____

Must be signed by a physician for any of these reasons:

□ prescription given more than 10 school days (daily medication)
□ over-the-counter more than 5 consecutive days
□ over-the-counter to be given at higher than labeled dose

Parent/Guardian: I give permission for district personnel to administer medication to my child in accordance with Texas Education Agency and District policies. I also acknowledge that it is the parent/guardian responsibility to maintain medication supply. Unclaimed medication will be destroyed at end of school year.	
Signature:	Date:
Printed Name:	Phone:

Physician: I request that the student receive this medication during the school day as instructed above.	
Signature:	Date:
Printed Name:	Phone:

School: Medication was received by:		
Signature:	Date:	Quantity Received:
Printed Name:	Phone Ext.:	Expiration Date: