

# 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.**

P A R E N T	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): _____
P H Y S I C I A N	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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Has the student been instructed in the use of the INHALER / EPI PEN? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Is the student able to self-administer the INHALER / EPI PEN? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Medication/Procedure Order Reviewed by Supervising RN: \_\_\_\_\_ Date: \_\_\_\_\_