TEXAS CENTER FOR ARTS + ACADEMICS | Texas Boys Choir, Fort Worth Academy of Fine Arts, Texas School of the Arts

PARENT/PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Requests for the administration of medications by school personnel may be made as follows:

1. A separate request form is to be completed for each medication.
2. Only those medications that cannot be given outside school hours will be administered. (Prescriptions can be written so that doses are not necessary during school hours.)
3. A written request from a student's physician will be required when non-prescription medication must be given longer than 10 consecutive school days.
4. Medication must be in the original, properly labeled container accompanied by this completed form (Texas Education Code 22.052). Please request the pharmacist to dispense two labeled bottles of medication: one for home and one for school.
5. It is the student's *responsibility* to come to the clinic or office to take his/her medication.
6. _____Please write *yes or no* if you give permission for your child to take home his/her medication at the completion of this request. Unused medication will be discarded after two weeks.

I hereby represent and attest that I am the legal guardian of the below-named student. I hereby request that the medication specified below be administered to the below-named student beginning on the following date:_____and ending on the following date_____. As long as a physician authorizes a refill of any prescription set forth above, this authorization shall apply to any such refills. On behalf of the above-named student, myself, and our personal representatives, family members, heirs, assigns, and successors, I also agree and do hereby waive and release all claims for loss damage, or injury against Texas Center for Arts + Academics and any teachers, employee, volunteer, agent or other person arising directly or indirectly out of any act or omission relating to the receipt, administration, or execution of this request.

Date of Request:_____ Student's Name:_____ Grade Level:_____

Condition for which medication is required:_____

Medication:_____ Time:_____

Date(s) to be administered:_____ Dosage:_____

Precautions/side effects of medications for your student:_____

_____

Physician's Name:_____ Phone Number:_____

I, the undersigned, the parent/guardian of _____ request that the above medication be administered to my child.

Signature _____
(Parent/Guardian) *(Home Phone)* *(Work Phone)*

Signature_____
(Physician, See #3 above) (Date) (Office Phone)

Parent/Guardian		Disposition	
Medication		Prescription Depleted	
Dosage		Medication Discontinued	
Prescription Stop Date		Medication Returned to Parent/Guardian	
		Medication Destroyed	

Week of	July M	T	W	TH	F
1					
2					
3					
4					
5					

Week of	August M	T	W	TH	F
1					
2					
3					
4					
5					

Week of	September M	T	W	TH	F
1					
2					
3					
4					
5					

Week of	October M	T	W	TH	F
1					
2					
3					
4					
5					

Week of	November M	T	W	TH	F
1					
2					
3					
4					
5					

Week of	December M	T	W	TH	F
1					
2					
3					
4					
5					

Week of	January M	T	W	TH	F
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2					
3					
4					
5					

Week of	February M	T	W	TH	F
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2					
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4					
5					

Week of	March M	T	W	TH	F
1					
2					
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4					
5					

Week of	April M	T	W	TH	F
1					
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5					

Week of	May M	T	W	TH	F
1					
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5					

Week of	June M	T	W	TH	F
1					
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3					
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5					