FORT WORTH ACADEMY OF FINE ARTS
Texas Center for Arts + Academics

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 signed request from the student's physician is required for the below listed prescription medication. (Also required for any **NON-PRESCRIPTION MEDICATION** to be administered by school staff 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. I, _____ ☐ **Do** ☐ **Do Not** give permission for my child to take home his/her unused medication at the completion of this request. Otherwise, unused medication will be discarded after two weeks.
7. As long as a physician authorizes a refill of any **PRESCRIPTION** set forth above, this authorization shall apply to any such refills.
8. 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: _____

Condition for which medication is required: _____

Medication: _____ Time: _____

Date(s) to be
Administered from: _____ to: _____ Dosage: _____
month/day/year month/day/year

Precautions/side effects of medications for your student: _____

_____

Physician's Name: _____ Phone Number: _____

_____ _____ _____
Physician Signature Office Phone Date

I, the undersigned, hereby represent and attest as the parent/guardian of _____ request that the above medication be administered to my child.

_____ _____ _____
Parent/Guardian Signature Home/Cell Phone Work Phone

THIS SIDE FOR SCHOOL PERSONNEL

Student's name: ____________________________________ **Grade** ________________

Medication __________________________ **Dosage** _________________

Date Medication received ____________________ **Expiration date of medication** ____________________

Amount of medication received ____________________________

DATE	TIME	NOTES