

**Abilene USD #435**  
**Request to Administer Medication at School**

Student: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Date Started: \_\_\_\_\_ Reason: \_\_\_\_\_

Time of day medication to be given: \_\_\_\_\_

Anticipated number of days to be administered at school: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<p><b><u>ASTHMA / DIABETIC / EPI-PEN STUDENTS ONLY</u></b></p> <p>This student is both capable and responsible for self-administering: ____No      ____Yes- supervised      ____Yes-unsupervised</p> <p>This student may carry his/her own insulin / inhaler / epi-pen: ____No      ____Yes</p>
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I hereby give my permission for \_\_\_\_\_ to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any drug to my student in accordance with written instructions from the physician/dentist shall not be liable for damages as a result of an adverse drug reaction suffered by the student. This student has had at least one dose of the medication and did not have an adverse drug reaction.

Date: \_\_\_\_\_  
Signature of parent/guardian \_\_\_\_\_

**\*\*\*\*Note: ALL prescriptions MUST be brought to school in the original container and properly labeled from pharmacy. Over the counter medications MUST be in the original container with student's name written on the package. If the medication does not have this signed form, and/or is not in the original container from the store or pharmacy --IT CANNOT BE GIVEN. \*\*\*\***

\_\_\_\_\_  
School Nurse