

**PORT NECHES-GROVES INDEPENDENT SCHOOL DISTRICT**

**Physician's Request for Administration of Medication**

**10**

**Campus:** \_\_\_\_\_

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

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

Condition for which drug is to be given:

Medication: (Include name of medicine, dosage, special instructions, possible reactions, if any, etc.)

**MEDICATION MUST BE SENT TO SCHOOL IN ORIGINAL CONTAINER**

Please note medications that are to be given three times daily, should be given at home before school, after school, and at bedtime.

Please schedule medication around lunchtime to keep classroom interruptions to a minimum.

The above medication may not be scheduled for other than school hours. Medication may be administered by a medically untrained designate of the school principal.

Physician's Name: \_\_\_\_\_  
(Please Print) Office Phone \_\_\_\_\_

The school cannot assume responsibility for adverse reactions to medications.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Date

\_\_\_\_\_  
Business Phone

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

\_\_\_\_\_  
Date filed in Nurse's Office