PORT NECHES-GROVES INDEPENDENT SCHOOL DISTRICT

Physician's Request for Administration of Medication

Campus: _____

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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 Office Fax

The school cannot assume responsibility for adverse reactions to medications.

_____ _____

✍ Parent's Signature ✍ Physician's Signature

_____ _____

Home Phone Date

_____ _____

Business Phone School Nurse

_____ _____

Cell Phone Date filed in Nurse's Office