ROCKWALL ISD
HEALTH SERVICES
HEALTHY CHILDREN, BETTER STUDENTS, HEALTHY COMMUNITIES

Permission to Administer Medication

Date of Request: _____

Student's Name: _____ **DOB:** _____ **Student ID#**_____

Allergies: _____ **School:** _____ **Teacher/Grade:** _____

Condition for which medication is given, side effects for child, special instructions, pertinent information:

_____

Medication name: _____ **Time(s) to be given at school**: _____

Amount and route to be given: _____

Medication Start Date: _____ **End Date:** _____

Is this the initial dose of a new medication? ☐ Yes ☐ No

☐ **Student may take morning dose of medication, if forgotten at home, with telephone permission from parent.**

Valid for one school year. Physician signature is **required** for all over-the-counter medications and off-label prescription medications. All medication must be in an original, properly labeled container and not expired.

Doctor's signature/stamp: _____

Doctor's phone number: _____

I request and authorize Rockwall ISD to administer the above medication(s) as prescribed. I understand that the school administrator may designate any qualified employee to administer this medication. I authorize the school registered nurse and the prescribing physician (print name) _____ to confidentially discuss or clarify this medication order, and to discuss the student's _____ (print name) response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

Parent/Guardian Signature: _____ **Date:** _____

Daytime Telephone(s): _____ **Email:** _____

FOR OFFICE USE ONLY

Medication Count/Expiration Date Check:

Date	# Pills	Exp. Date	Counter's Initials	Witness Initials	Date	# Pills	Exp. Date	Counter's Signature	Witness Initials

Signature/Initials of Person Administering Medication or Counting

_____/_____ _____/_____

_____/_____ _____/_____