ERA INDEPENDENT SCHOOL DISTRICT

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Medication Request Form

Only those medications that are medically necessary during school hours for a student's attendance or written in an IEP should be sent to school. School personnel are not to be held responsible for any ill effects that might occur from this medication.

Persons who may assist your child with medications include trained campus staff, school nurse, or school health assistant. The medication must be in the original container and properly labeled containers, one for school and one for home. THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ILLNESS MAY NOT BE GIVEN AT SCHOOL.

Over-the-counter Medications needed longer than two weeks must have review and approval of the school nurse and may require a physician's order. All medication must be clearly labeled with the student's full name (either printed on the pharmacy label, or written on the container).

Student Name: **Date of Birth:** **Grade:**

Medication:

Dosage *(amount)*:

Instructions: *(how is the medication administered)*:

Reason for Medication:

☐ *For episodic/emergency events only*

Medication to be given From: ***(Date)*** **To:** ***(Date)***

When was the first dose given?			

Restrictions and/or side effects? *(if "yes", please describe)*

I give permission for (name of child)_____to receive the above medication at school according to standard school policy (FFAC Legal and Local).

Parent/Guardian Signature: **Date:**

Daytime Phone Number:

Reviewed by Nurse (date): **Health assistant may may not administer.**

Nurse's Printed Name: **Nurse's Signature:**