



HEALTH SERVICES PHS FAX: 469-593-5216  
Richardson Independent School District

2009-2010

**Parent/Physician Request for Administration of Medication by School Personnel**

Date of Request: \_\_\_\_\_ School: \_\_\_\_\_ Teacher/Grade: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Medication: \_\_\_\_\_ Exp. Date \_\_\_\_\_ Dosage: \_\_\_\_\_

Is this the initial dose of a new medication that has not been previously administered to your child? YES NO

Time to be Administered: \_\_\_\_\_ Dates to be Administered: \_\_\_\_\_

Condition for which medication is required: \_\_\_\_\_

Special Instructions/Precautions/Side Effects of medication on your child: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

\*Physician's Signature: \_\_\_\_\_

My signature below indicates that I request that RISD staff administer the medication specified above to my child, and I am giving permission for RISD staff to contact the physician for additional information, if needed.

Parent/Guardian Signature: \_\_\_\_\_ Email: \_\_\_\_\_

Parent's Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

*\*Physician's signature is required to administer over-the-counter medications for more than 10 consecutive school days from the date of the original request.*

Only a 30-day supply of medication will be accepted at a time.

***FOR OFFICE USE ONLY!***

Entered in Star Student

**Medication Count:**

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

**Comments (Indicated by \* on back of form):**

Date	Comments	Date	Comments

Date	RN Review

Medication returned to: Parent / Student \_\_\_\_\_ Date \_\_\_\_\_  
Print Signature

STUDENT'S NAME: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ DOSAGE: \_\_\_\_\_ TIME: \_\_\_\_\_

DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY
1												1
2												2
3												3
4												4
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31												31
DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY

**CHARTING CODES**

A	DC	FT	H	OOM	R	SF	*
Absent	Discontinued	Field Trip	Hold	Out of Medication	REACH	Sent For	Comments

\* Indicates Comments on front of form