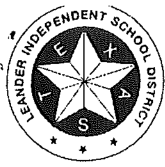

LEANDER INDEPENDENT SCHOOL DISTRICT
REQUEST TO ADMINISTER MEDICATION

REQUEST TO ADMINISTER MEDICATION

I request that designated personnel of Leander ISD administer the medication listed below to my child according to the label and/or physician instructions. I agree to furnish an adequate amount of medication in the original container. I understand that Leander ISD personnel will protect my child and not administer medication if this form is not completed or the medication is not furnished as required.

Please note: Non-Prescription/Prescription Medication cannot be sent home with the Student

At the end of the school year (circle one): Dispose of medication Parent will pick up

**********Note: All remaining medications will be disposed of on the last day of school**********

See back for more detailed information. Call your campus clinic at 512-570-7027 for any questions.

Completed requests can be faxed to 512-570-9213 __.

Prescription Medication

Name of Student: ________________ DOB: ________ Age: _____ Grade: _____ Teacher: ________________

Name of Medication: ________________ Exp. Date: ________ Dosage: ________________

Condition for which the medication is prescribed: ________________

Time(s) to be given at school: ________________ Do not administer after the following date: ________________

Side effects: ________________

Physician's printed name: ________________ Physician's Signature: ________________

Physician's Telephone: ________________ Physician's Fax: ________________ Date: ________________

I give permission to my child's school to administer the prescribed medication in accordance with the physician's instructions above. I also give permission for the school to contact the above health care provider about the administration of this medication. I understand that the School District, the Board and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medication to a student, provided such administration conforms to the requirements of this policy.

Parent/Guardian Printed Name: ________________ Parent/Guardian Signature: ________________

Home: ________________ Work: ________________ Cell: ________________

Email address: ________________ Date: ________________

Non-Prescription Medication

Name of Student: ________________ DOB: ________ Age: _____ Grade: _____ Teacher: ________________

Name of Medication: ________________ Exp. Date: ________ Dosage: ________________

Time(s) to be given at school: ________________ Do not administer after the following date: ________________

I understand that the School District, the Board and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medication to a student, provided such administration conforms to the requirements of this policy.

Parent/Guardian Printed Name: ________________ Parent/Guardian Signature: ________________

Home: ________________ Work: ________________ Cell: ________________

Email address: ________________ Date: ________________