



### MEDICATION PERMISSION REQUEST FORM

Parents/Guardians:

The Seguin Independent School District has outline the steps that must be taken before prescribed medication is dispensed to students on campus. We want to assist you and your child in understanding these rules so that he/she is not in serious violation of the Seguin ISD Student Code of Conduct and subject to disciplinary action.

Students are not allowed to carry any medications on their person unless otherwise prescribed by their physician and written orders stating as such, this also includes non-prescription medications. Medications will be maintained and dispensed by health personnel. The following steps must be taken before a student is allowed to take medication at school.

1. Parent/Guardian must present this completed consent form to the campus nurse or a prescription written and signed by the ordering physician.
2. Parent/Guardian must bring the medication in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by law. Prescription bottles must be current within 45 days.
3. Long term medication (more than 10 days) maybe given by District personnel provided that the prescribing health care provider completes the remainder of this form.

Student: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ ID#: \_\_\_\_\_

### THE FOLLOWING TO BE COMPLETED ONLY BY HEALTH CARE PROVIDER OR SCHOOL NURSE

Medication	Strength	Dose	Time (at school)	Route

Allergies: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

\_\_\_\_\_  
 Printed Name of Health Care Provider                      Phone                      Verified by School Nurse                      Date

### TO BE COMPLETED BY PARENT

I, \_\_\_\_\_, give permission for my child to receive the above medication as directed. I give my permission for my child's physician to share written or verbal information with the School Nurse for the duration of the school year regarding their medication(s) and diagnosis.

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Numbers: Cell/Home: \_\_\_\_\_ Work: \_\_\_\_\_

### MEDICATION RECEIVED AND COUNTED

Total: Pills: \_\_\_\_\_ ML's/CC's: \_\_\_\_\_ Parent Initials: \_\_\_\_\_ Clinic Staff Initials: \_\_\_\_\_ Date \_\_\_\_\_

