Neurology Department

PHYSICIAN REQUEST FOR ADMINISTRATION
OF MEDICATION BY SCHOOL PERSONNEL FOR THE 2012-2013 SCHOOL YEAR

214-456-2768

Prescribed medication may be administered by school nurse or by a non-health professional designee of the principal or school nurse. The medication should be in original container appropriately labeled by the pharmacy. This completed form along with the medication and/or special equipment items are to be brought to the school by the parent.

Student _____ DOB_____
Parent(s) Name _____ Phone _____
Address/City/Zip _____
School _____ Grade _____

1. **Condition for which prescribed medication/treatment is required:** _____
2. **Medication, Dose and Method of Administration (include time schedule):**
   A. _____
   B. _____
   C. _____
   D. _____
3. **Precautions, unfavorable reactions:** _____

_____

4. Disposition of pupil following administration or procedure, if applicable, i.e. rest, home, hospital, doctor's office, return to class. _____

SIGNATURE OF THE PHYSICIAN — NAME (Please print) and Date

2350 Stemmons Freeway, 5th Floor, Suite 5400, Dallas , TX 75207
ADDRESS

_____
TELEPHONE NUMBER

(PARENT)

We (I) the undersigned, the parents/guardian of _____ request the above medication or procedure be administered to our (my) child. We (I) authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed above.

_____/ _____ Telephone _____/_____
Name — Relationship — Home — Business

_____/ _____ Telephone _____/_____
Name — Relationship — Home — Business