Seguin INDEPENDENT SCHOOL DISTRICT
exceptional students to exceptional citizens

MEDICATION PERMISSION REQUEST FORM

Student:_____ DOB:_____

School:_____ Grade:_____ ID#: _____

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 within45 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.

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 _____