Student's Last Name First Name Allergies Gr/Teacher/ID#

Plano Independent School District

Medication Request Form

Please follow the guidelines below when bringing medication to school:

1. For student safety, **all medication should be brought to the school by the parent. Controlled substances must be brought to the clinic by the parent.** Medications **are not** provided by the school.
2. **All medication** must be in its original, properly labeled container with a written request signed by the parent/guardian and must be administered according to the labeled instructions or a medical order.
3. Only medication that cannot be given at home will be given at school.
4. Only a 30 day supply of medication will be accepted at a time. **(Amount received by nurse _____)**
5. **Medication that has expired or is not picked up by the parent will be destroyed.**
6. Authorized district employees may administer medication in the absence of the nurse.
7. Aspirin or products containing aspirin will not be given without a physician's order.
8. Nonprescription, homeopathic medication, dietary supplements and herbal supplements will only be given in accordance with Plano ISD Board Policies FFAC(LEGAL) and FFAC(LOCAL).

Medication: _____ Prescription Number: _____
Dosage: _____ Route: _____ Time: _____ Days to give: _____

Will this be the first dose of a new medication for your child? ☐ Yes ☐ No
Expiration Date (Responsibility of Parent): _____
What is the condition for which this medication is required? _____
_____
Special instructions / precautions / side effects of this medication for your child? _____
_____

By my signature below, I affirm that it is impossible to schedule the above mentioned medication at a time other than school hours. I request that this medication be given by a school employee. I acknowledge that I will not hold the Plano ISD, Board of Trustees, and / or District employees for damages or injuries resulting from administration of this medication (prescription / nonprescription / homeopathic / over the counter, dietary supplement and / or herbal supplement.)

Parent / Guardian Authorization for School Staff to Communicate Health Information:

I authorize the District's designees, including District medical professionals and UAP's to share / obtain my student's health related information with the medical health professional or health care provider identified below to plan, implement or clarify actions necessary in the administration of school health related services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP or other PISD form requesting for school health care services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Care Information. School-related health services described herein shall not be provided to a student without the required consent of the parent / guardian, as outlined herein.

Parent Signature: _____ Date: _____ Phone #: _____
Parent Printed Name: _____E-mail address: _____
Name of Student's Healthcare Provider: _____ Phone # _____

A physician's signature is required to administer over the counter medication for **more than 10 consecutive days**.
Physician's Signature: _____ Date: _____
Physician's Printed Name: _____ Telephone: _____