**POINT ISABEL INDEPENDENT SCHOOL DISTRICT**
**101 Port Road, Port Isabel, Texas 78578**

## PARENT'S REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL

I request school personnel see that my child _____ DOB: _____

Be given this medicine _____ dose _____

Prescribed by _____ starting _____
Physician's Name Date

For _____ _____
Length of Time Physician's Signature Phone

Prescription medication will be furnished by me in pharmacy packaging with my child's name, the name of the medicine, the dose to be given, the frequency and the length of treatment. Doses will be administered as per written instructions only. Over the counter medications in original packaging with a parent signature are limited to **three consecutive days** of use. All prescription medications must be accompanied by a medical practitioner's signature.

The Principal/and or Nurse may call the doctor if there are any questions. Medications that are prescribed once or twice a day can be given at home. If there is a clear reason school personnel should give the medicine, please have the practitioner ordering the medicine write that down. Information may be faxed to the school the child is attending:

**Garriga Elementary** (956) 943-0086 (0640) Fax
**Derry Elementary** (956) 943-0073 (0074) Fax
**Jr. High** (956) 943-0102 (0055) Fax
**High School** (956) 943-0036 (0648) Fax

Should school personnel feel that it is in the best interest of my child that the medication not be given on a certain day, they will notify me.

Name of Medication: _____

Reason for Medication: _____

Time to be Given: _____

Allergies to drugs: _____

Parent Signature: _____

Parent Phone Number: _____ Date: _____