MOODY I.S.D.

PHYSICIAN REQUEST FOR MEDICATION ADMINISTRATION AT SCHOOL

STUDENT: _____

DOB: _____ PHONE NUMBER: _____

TO BE COMPLETED BY PHYSICIAN:

Medication Name: _____ Dosage: _____

Directions: _____ Duration: _____

Medication Name: _____ Dosage: _____

Directions: _____ Duration: _____

STUDENT MAY CARRY AND SELF ADMINISTER INHALER YES NO (CIRCLE ONE)

Medications may be administered by medically untrained designates of the school district.

Physician's Name (printed) _____

Physician's Phone Number _____

Physician's Signature: _____

(Physician's signature is required for administration of all prescription medications, including Inhalers that are self-administered; signature is also required for over the counter medications that are to be given for more than three (3) consecutive days).

PARENT / GUARDIAN: I GIVE PERMISSION FOR MY STUDENT, _____, TO RECEIVE THE ABOVE MEDICATION AS DIRECTED. I UNDERSTAND THAT MEDICATION THAT IS GIVEN AT SCHOOL MAY BE ADMINISTRATED BY MEDICALLY UNTRAINED DESIGNATES OF THE SCHOOL DISTRICT.

PARENT'S SIGNATURE **DATE**