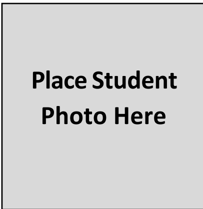
CONROE INDEPENDENT SCHOOL DISTRICT
Health Services

# Parent Request for Administration of Medication by School Personnel




CONFIDENTIAL

SCHOOL YEAR ___________________

Teacher_________________________GR_______________

Parent/Guardian email _____________________________

Date Entered in eSchoolPlus _________ Nurse Init._______

**Student Name**____________________________________________________________**Student ID**______________________**DOB**______________________________

*As the Parent / Guardian of the above named child, I give my permission for him / her to be given the medication as described below by whomever the principal designates. I understand medication will be handled according to recommended Conroe ISD Policy and Procedure, TEA recommendations and FDA Guidelines.*

**Printed Name of Parent/Guardian** ____________________________________________________**Daytime Phone Number(s)**_________________________________

**Signature** _________________________________________**Relationship to Student** (Ex. Mom, Step Parent, Etc.) __________________**Today's Date** ____________________

| Name of Medication | | Medication Strength | Dosage | |
|---|---|---|---|---|
| Route of Administration: ☐ by mouth ☐ inhaled ☐ topical ☐ eye(s) ☐ ear(s) ☐ nasal ☐ injection: (☐IM ☐SQ☐IV) ☐rectal | | | Medication Start Date | Medication End Date |
| Reason for Taking | | | | |
| Give Daily Time(s): | OR | Give PRN/As Needed Frequency: | | |
| Special Instructions | | | | |
| Other Medication(s) Student is Taking | | | | |

**IF THERE IS A CHANGE IN DOSAGE, AMOUNT, OR TIME, FILL OUT A NEW MEDICATION PERMISSION FORM.**

| MEDICATION CHECK-IN | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Date Received | Time In | Amount/ Number | Pill Description (Match to Label) | Medication/ RX Expiration | Clinic Staff Signature | Parent/Guardian Signature | Reconciled Date | Nurse Verified |
| Original | | | | | | | | |
| REFILL(S) | | | | | | | | |
| #1 | | | | | | | | |
| #2 | | | | | | | | |
| #3 | | | | | | | | |
| #4 | | | | | | | | |
| #5 | | | | | | | | |
| #6 | | | | | | | | |

Physician Name ___________________________________ Physician Signature _____________________________________Physician Phone Number___________________Date__________

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**Med. Pick-Up Date**__________________**Time**__________ **By /Sign**___________________________________**Relationship**____________________________**Count** _________ **Staff Initials**___________

**Parent Request for Administration of Medication by School Personnel**

CONROE
INDEPENDENT SCHOOL DISTRICT
**Health Services**

**2024-2025**

**CONFIDENTIAL**

**Student Name** ______________________ **DOB** __________ **ID#** __________

**Name of Medication** ______________________ **Grade** __________

## AUGUST

| Date | M | T | W | TH | F |
|---|---|---|---|---|---|
| 1-2 | | | | | |
| 5-9 | | | | | |
| 12-16 | | | | | |
| 19-23 | | | | | |
| 26-30 | | | | | |

## SEPTEMBER

| Date | M | T | W | TH | F |
|---|---|---|---|---|---|
| 2-6 | | | | | |
| 9-13 | | | | | |
| 16-20 | | | | | |
| 23-27 | | | | | |
| 30 | | | | | |

## OCTOBER

| Date | M | T | W | TH | F |
|---|---|---|---|---|---|
| 1-4 | | | | | |
| 7-11 | | | | | |
| 14-18 | | | | | |
| 21-25 | | | | | |
| 28-31 | | | | | |

## NOVEMBER

| Date | M | T | W | TH | F |
|---|---|---|---|---|---|
| 1 | | | | | |
| 4-8 | | | | | |
| 11-15 | | | | | |
| 18-22 | | | | | |
| 25-29 | | | | | |

## DECEMBER

| Date | M | T | W | TH | F |
|---|---|---|---|---|---|
| 2-6 | | | | | |
| 9-13 | | | | | |
| 16-20 | | | | | |
| 23-27 | | | | | |
| 30-31 | | | | | |

## JANUARY

| Date | M | T | W | TH | F |
|---|---|---|---|---|---|
| 1-3 | | | | | |
| 6-10 | | | | | |
| 13-17 | | | | | |
| 20-24 | | | | | |
| 27-31 | | | | | |

## FEBRUARY

| Date | M | T | W | TH | F |
|---|---|---|---|---|---|
| 3-7 | | | | | |
| 10-14 | | | | | |
| 17-21 | | | | | |
| 24-28 | | | | | |
| | | | | | |

## MARCH

| Date | M | T | W | TH | F |
|---|---|---|---|---|---|
| 3-7 | | | | | |
| 10-14 | | | | | |
| 17-21 | | | | | |
| 24-28 | | | | | |
| 31 | | | | | |

## APRIL

| Date | M | T | W | TH | F |
|---|---|---|---|---|---|
| 1-4 | | | | | |
| 7-11 | | | | | |
| 14-18 | | | | | |
| 21-25 | | | | | |
| 28-30 | | | | | |

## MAY

| Date | M | T | W | TH | F |
|---|---|---|---|---|---|
| 1-2 | | | | | |
| 5-9 | | | | | |
| 12-16 | | | | | |
| 19-23 | | | | | |
| 26-30 | | | | | |

## JUNE

| Date | M | T | W | TH | F |
|---|---|---|---|---|---|
| 2-6 | | | | | |
| 9-13 | | | | | |
| 16-20 | | | | | |
| 23-27 | | | | | |
| 30 | | | | | |

## SIGNATURES

Name/Initials ______________________

Name/Initials ______________________

Name/Initials ______________________

Name/Initials ______________________

Name/Initials ______________________

Comments/Notes: