Klondike Independent School District
Request for Administration of Medication at School

2911 County Rd. H
Lamesa, Tx 79331
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This form must be filled out completely in order for school health staff to administer medication to a student. A new medication authorization form must be completed at the beginning of each school year, for each medication, and each time there is a change in the medication's administration instructions. The following is required by the provider of the medication according to Texas Education Code's, Chapter 22, Section 22.052:

- Prescription and non-prescription medication must be delivered to school in its original container.
- The container must be properly labeled by a pharmacist or the prescribing physician.

Student's Name _____ Sex _____
Date of Birth _____ /_____/_____ Teacher/Homeroom _____
Condition for which medication is being administered _____
Medication Name _____ Dose _____ Route _____
Times(s) of day to administer _____
Medication shall be administered from: ___/____/____ to: ____/____/____
Possible side effects _____
Special requirements for administration/storage _____
Known Food or Drug Allergies: YES ___ NO ___
If Yes, please explain: _____
Prescriber's Name _____Telephone _____ - _____ - _____
Address _____
Prescriber's Signature _____ Date _____

PARENT/GUARDIAN AUTHORIZATION

I request that school health staff administer the medication as described above by my child's primary prescriber. I consent to medication administration for my child named above and agree to review and provide any special instructions for the administration of child's medication, and share that information with my child's school health staff.
Parent/Guardian Signature _____ Date _____
Cell Phone: ____ - ____ - ____ Home Phone: ____ - ____ - ____
Work Phone: ____ - ____ - ____

OFFICE USE ONLY

Medication was received from _____ Date _____
Medication was received by _____ Date_____
Initial Count (pills or tablets) or Measurement (liquids)_____
Witness Signature _____Date_____