HUTTO ISD

Health Services

Medication Administration Form

School Year:

Campus:

Student Last Name	Student First Name	DOB	Grade/Teacher
Medication		Expiration Date	
Dose	Route	Time(s)	
Condition for Which Medication is Required			
Specific Instructions/Precautions			
Pharmacy Name		Pharmacy Number	

❒Yes ❒No **Is this the initial dose of a new medication that has not been previously given to your child?**

❒Yes ❒No **If noon med: My Child is to receive medication prior to release on early dismissal days**

❒Yes ❒No **Will your child need this medication during field trips?**

My signature below indicates that I request and grant permission to HUTTO ISD staff to administer medication to my child. I am giving permission to HISD staff to contact my physician for additional information if necessary. If the school nurse deems it necessary, I grant permission to notify my child's teacher(s) of possible reactions that might occur while taking this medication. I understand that unlicensed school personnel assigned by the principal may give the medication. I understand that a new parent and physician authorization is required for any change in the dosage or time of this medication. I understand my child cannot carry this medication unless permitted by law and that a parent/guardian must bring and pick up any medication given at school. I understand all medication will be disposed of on the last day of school unless picked up by parents/guardians.

Name	
Signature	
Date	Phone

For HISD Staff Use Only

Student Last Name	Student First Name	DOB	Grade/Teacher
Medication		Expiration Date	
Dose	Route	Time(s)	

Trained Staff Name	**Signature**	**Initials**	**Date**

Date	Number Pills/ml	Received By Name	Received By Signature	Witnessed By Name	Witness By Signature
Medication Picked Up By					
Date	Number Pills/ml	Pick Up By Name	Picked Up By Signature	Released By Name	Released By Signature
Medication Disposal					
Date	Number Pills/ml	Disposed By Name	Disposed By Signature	Witnessed By Name	Witnessed By Signature