FRISCO ISD
School Health Services

MEDICATION: PARENT/GUARDIAN REQUEST FORM

Student Name: _____ **Grade:** _____

Student ID Number/Teacher: _____ **DOB:** _____

I do hereby request that school personnel of Frisco Independent School District administer the medication set forth below to my child. The medication must be administered during school hours and I cannot personally supervise this activity. I have supplied all information concerning the dosage of the medication and method of administration or requested that it be supplied by my child's physician. I do hereby release the Frisco Independent School District, its agents, servants, employees, and medical advisors from any liability in connection with the administration of this medication.

I understand that my child requires medication(s) to be on hand during field trips away from the school campus. I give my permission for the school to send this medication (these medications) on the field trip with my child. All medication (s) will be sent in a single dose container and clearly marked with my child's name and instructions. An assigned teacher who has been given instructions, has verbalized understanding of medication administration and has performed demonstration of medication administration, will be in charge of dispensing the required medication as directed on the field trip.

District approved medications include: Acetaminophen (Tylenol), Ibuprofen (Advil/Motrin), Tums, Benadryl, Generic equivalents are acceptable. Note: Ten doses of the District approved medications will be administered without a physician's signature. Subsequent doses will require a prescription.

Medication: _____	Medication: _____
Time: _____	Time: _____
Start Date: _____ End Date: _____	Start Date: _____ End Date: _____
Dosage and Route: _____	Dosage and Route: _____
Special Instructions: _____	Special Instructions: _____

Physician's Name Printed: _____ Physician's Phone: _____

Physician's Signature (if needed): _____

Information concerning this medication and my child's health may be shared with/obtained from the above named physician. Please check one: ☐ Yes ☐ No

Parent/Guardian Signature: _____ **Date:** _____

(Parent/Guardian must sign and date this form and give to school nurse when bringing medicine to school clinic.)

Nurse tracking of number of OTC doses administered. *For Nurse use only.*

OTC Med:	Exp. Date:	OTC Med:	Exp. Date:
1. _____	6. _____	1. _____	6. _____
2. _____	7. _____	2. _____	7. _____
3. _____	8. _____	3. _____	8. _____
4. _____	9. _____	4. _____	9. _____
5. _____	10. _____	5. _____	10. _____