Alvin Independent School District
Parental Request for Administration of Medication by School Personnel

Student's Name	Date of birth	Grade	Teacher

Name of Medication		Dosage	Time to be Administered
Date to Begin Medication	Date to End Medication	☐ Leave Medication at School	☐ Send Medication Home Daily
Condition for which medication is required		Medication Expiration Date	
Physician's Name		Physician's Phone Number	

My signature below authorizes Alvin Independent School District personnel to administer my child (named above), the medication (specified above) as prescribed or according to the label directions. In addition, I am giving permission for Alvin Independent School District personnel to contact the prescribing physician for additional information, if needed.

Parent/Guardian Name	Parent/Guardian Signature	Date
Parent/Guardian Daytime Phone	Parent/Guardian Cell Phone	Parent/Guardian Email

A physician's order is required to administer over-the-counter medication/s for more than 10 consecutive days from the date of the original request. Alvin ISD staff will not administer medications that are ordered every morning, once a day or every 8 or 12 hours. These medications should be given at home. Note: All prescription medications, other than inhalers, will need to be picked up by the parent/guardian on or before the last day of school. I give permission for the nurse to send home over the counter meds when discontinued or the last week of school. Yes ☐ No ☐

FOR CLINIC USE ONLY

Date	Notes

Receive/return medication—Document witnessed pill count of all controlled medications received, returned, or intra-district transfer to new campus (count at both sending and receiving campus). Witness: Parent or AISD staff member

Date	Medication	Amount received	Amount returned	Signature	Witness signature

Personnel Name (Print)	Personnel Signature	Personnel Initials
Personnel Name (Print)	Personnel Signature	Personnel Initials
Personnel Name (Print)	Personnel Signature	Personnel Initials
Personnel Name (Print)	Personnel Signature	Personnel Initials
Personnel Name (Print)	Personnel Signature	Personnel Initials

Student Name: _____ **Teacher:** _____

Medication: _____ **Dosage:** _____ **Time:** _____

SCHOOL YEAR 2022-2023

DAY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	DAY
1												1
2												2
3												3
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CHARTING CODES

A	DC	ED	FT	H	LE	NM	*
Absent	Discontinued	Early Dismissal	Field Trip	Hold	Student Left Early	No Medication	Note on front of form

Controlled medication count witnessed and # of pills charted inside the box on the first day of each week. Witness to sign front of form.