New Diana Independent School District

11826 State Hwy 154 E.
Diana, Texas 75640
903-663-8000

Medication Administration Request

Parents please note this form must be completed by your doctor before ANY MEDICATIONS can be given to your child at school. This also includes over the counter medications. If your child needs medications, please bring a completed request and the necessary medication in the original container of the nurse's office. **DO NOT SEND IT WITH YOUR CHILD.**

DATE: _____CAMPUS:_____
STUDENT: _____DATE OF BIRTH: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER:

MEDICATION: _____
REASON FOR MEDICATION: _____
MEDICATIONDIRECTIONS/ORDERS: _____
_____
RESTRICTIONS OR SIDE EFFECTS: _____
_____
MEDICATION TO BE ADMINISTERED FROM_____TO_____

The student is both capable and responsible for self-administering this medication. ____YES____NO
Student may carry this medication: _____YES_____NO

PHYSICIANS NAME/TITLE_____
ADDRESS_____
PHONE_____FAX:_____
PHYSICIANS
SIGNATURE_____DATE:_____

PARENT/GUARDIAN AUTHORIZATION

I give permission for (student's name) _____, to receive the above medication at school according to standard school policy.
I give permission for the school nurse to communicate with the student's teacher about student's diagnosis and medication if needed. Yes____No____.

Parent/Guardian Signature **Relationship** **Date**