

Benavides ISD Medication Request Form Over the Counter (OTC) or Non-prescription medication

PARENT REQUEST FOR ADMINISTRATION OF MEDICATION

Benavides ISD

Phone: (361-256-3031)

Fax: (361-256-3032)

OVER THE COUNTER MEDICATION:

Start date: _____ Stop date: _____

Student's name: _____ D.O.B. _____

Medication (generic name if used) _____

Dosage amount: _____ Time to be administered at school: _____

Condition for which medication is to be given: _____

Allergies: _____

Possible adverse reactions: _____

I understand that a person who is not medically licensed may administer the medication and/or treatment. I understand that (1) that in accordance with Texas Education Code, 21.905 medication is defined as: Substances used to prevent, diagnose, cure, or relieve signs and symptoms of disease; (2) there is no liability on the part of Benavides ISD (Elementary or High School), or its employees for administration of medication requested by the parent/guardian and for adverse reactions or side effects to the medication; (3) I agree to be responsible for maintaining an adequate supply of medication at the school to meet the child's needs; (4) this medication will be brought to school only by a parent/guardian; (5) that my child will not be in possession of any medication at any time unless they have written permission from a physician stating they have a condition that requires immediate treatment; (6) this medication will be "properly labeled;" (7) this medication will be destroyed if it is not picked up; (8) in accordance with the Nurse Practice Act, Texas Code, Section 217.11, the school nurse has the responsibility and authority to refuse to administer medications that in the nurse's judgment are not in the best interest of the student. I hereby authorize the exchange of medical information regarding my child's medication/treatment plan between the physician and Benavides ISD Health Services Department. The most current request, label on medication, and student medication log all must have matching information. Consequently, if all three do not match your child will not receive the medication at school. Medication labels must also be dated.

Filed in Nurses office and medication received on: _____ Quantity: _____ By: _____

This medication will be destroyed if not picked up by: _____

Dose label on medicine and parent request match? _____ YES _____ NO

Parent/guardian Signature: _____ Date: _____

Print Name: _____ Phone: _____

Emergency phone number _____