Form H-72—2,500--10027—07
SC-03-00015

Dallas Independent School District

# PHYSICIAN/PARENT REQUEST FOR ADMINISTRATION OF MEDICINE OR SPECIAL PROCEDURE BY SCHOOL PERSONNEL

FILED IN NURSE'S OFFICE ON _____ BY _____

Special health care procedures and medications may be administered at school by personnel when such treatment is necessary for school attendance and cannot otherwise be accomplished. Prescribed medication/treatment may be administered by a school nurse or by a non-health professional designate of the principal or school nurse. The medication is to be in the original container appropriately labeled by the pharmacy. Parents may request that the pharmacist dispense two bottles of medication, one for home and one for school. This completed form along with the medication and/or special equipment items are to be brought to the school by the parent.

THIS INFORMATION IS CURRENT UNTIL NEW OR UPDATED INFORMATION IS RECEIVED OR FOR ONE CALENDAR YEAR FROM DATE OR UPDATE OF REQUEST.

1. Name of Pupil_____ Birth Date_____
2. Address_____ School_____
3. Condition for which prescribed treatment is required:_____ ICD 10 Code_____
4. Specific medication or procedure:
5. Dosage and method of administration/instruction (include time schedule), time, protocol required for special health care procedure.
6. Precautions, unfavorable reactions:
7. Disposition of pupil following administration or procedure, if applicable, i.e., rest, home, hospital, doctor's office, return to class.
8. Date of Request_____ Date of Termination_____
9. _____/_____
   *Physician's Name (printed)* *Signature*
   _____/_____
   *Physician's Address* *Telephone Number*

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(PARENT)

We (I), the undersigned, the parents/guardians of _____
*Student's Name*

request the above medication or procedure be administered to our (my) child. We (I) authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed above.

_____/_____ Telephone _____/_____
*Name* *Relationship* *Home* *Business*

_____/_____ Telephone _____/_____
*Name* *Relationship* *Home* *Business*

**NOTE:** Prescribed asthma inhaler may be kept by the student and self-administered if the physician indicates this need in writing and considers the student sufficiently responsible. In addition, the physician should list any precautions to be followed on this form (the school nurse will inform the principal and appropriate others.)