Lubbock ISD
Every Child Every Day

Health Services
Telephone: (806) 219-0466
Fax: (806) 766-6680

COPY MEDICATION LOG ON BACK OF FORM

Medication Administration Request

When it is necessary for your child to receive medication during the school day:

- **Parents/guardians must provide and deliver all medications to the school**. Do not send more than a 30 day supply of medications.
- All medication must be in the **original container**, clearly labeled with the student's name, the dosage and/or age appropriate dose of medication and directions for administration.
- The Medication Administration Request must be completed each school year *and* when there are any changes to the original request including a medication and/or dose change. A separate form must be completed for each medication even when the same medicine is to be given twice during the school day.
- Only FDA approved pharmaceuticals (prescription and non-prescription) manufactured within the United States will be administered. **Homeopathic preparations & allergy injections will not be accepted.**
- Parents/guardians are strongly encouraged to pick up all medication immediately after it is discontinued. **At The End Of The School Year, All Medication That Has Not Been Picked Up By The Parent/Guardian Will Be Destroyed.**

Date: _____ **Student:** _____ **DOB:** _____

Allergies: _____ **Teacher:** _____ **Grade:** _____

Medication: _____ **Dose:** _____ **Expiration Date:** _____

TIME to be administered: _____ **DATES to be administered:** _____

CONDITION for which medication is required: _____

Special Instructions / Precautions / Side Effects of medication on your child: _____

☐ **YES-STUDENT may take morning dose of medication at school, if forgotten at home, with parent permission by phone.**

PHYSICIAN'S Name: _____ **Phone:** _____

My signature below indicates that I request that LISD staff administer the medication specified above to my child, and I am giving my permission for LISD staff to contact the physician for additional information, if needed.

PARENT/GUARDIAN NAME _____ **SIGNATURE:** _____

Phone (Home): _____ **(Work):** _____ **(Cell):** _____

Email address: _____

Medication Count: **(Controlled Medications Must Be Counted)** ***FOR LISD STAFF ONLY!***

Date	# Pills	Counter's Signature	Witness Signature	Date	# Pills	Counter's Signature	Witness Signature

Comments: **(Indicated by * on Back of Form)**

Date	Comments	Date	Comments	Date	Nurse Review	Date	Nurse Review

End-Of-Year Medication Dispensation: **(HSC=Health Services Coordinator)**

Dates Letter Sent Home-OPTIONAL	Initials	Dates Phone Contact Attempted-OPTIONAL	Initials	Date Med Picked Up by Parent/Guardian-REQUIRED	Initials
				Date Med to HSC to be Destroyed-REQUIRED	Initials