IOWA PARK CISD
PRESCRIPTION MEDICATION REQUEST FORM

This section must be completed by the prescribing Physician

Name of Student: _____Date of Birth: _____Grade: _____

Medication Prescribed: _____

Dosage: _____Time: _____

If Epi-pen, please list allergens: _____

Start Date: _____Stop: Date: _____

Physician's Name: _____ Physician's Signature: _____

Physician's Address: _____ Phone Number: _____

IF THE ORDERED MEDICATION IS AN INHALER, PHYSICIAN APPROVAL REQUIRED BELOW:

May this student carry an INHALER on self during the day? Yes: _____ No: _____
Has the student been instructed in the use of the INHALER? Yes: _____ No: _____
Is the student able to self-administer the INHALER? Yes: _____ No: _____

Physician signature: _____

This section must be completed by the Parent/Guardian

Parent/Guardian Print: _____Signature: _____

Phone Number: _____ Other: _____

I request the above medication to be given to my child during school hours or outside of school hours at any school related functions. I fully understand that trained NON-MEDICAL District personnel may administer this medication. I understand that the School District, the Board, and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of a medicine to a student, provided such administration conforms to the requirements of this policy.

Parent/guardian is responsible for picking up any unused medication at the end of the school year. Any medication not picked up, will be disposed of. New forms are required each school year.

School	Phone	Fax
Kidwell Elementary	940-592-4322	940-592-2487
Bradford Elementary	940-592-5841	940-592-2059
WF George Middle School	940-592-2196	940-592-2801
Iowa Park High School	940-592-2144	940-592-2583
