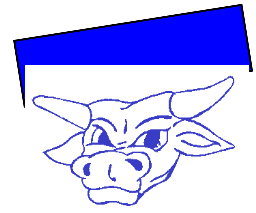
George West ISD
George West, Texas 78022
361-449-1914 ext 1062-School Nurse
361-449-8921 - fax



PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

DATE: _________________

NAME OF STUDENT: ____

DATE OF BIRTH: ______________________ **GRADE:** ____________________

CONDITION(S) FOR WHICH MEDICATION IS TO BE GIVEN:

MEDICATION:

DOSAGE, TIME, AND METHOD OF ADMINISTRATION (SPECIAL INSTRUCTIONS, POSSIBLE REACTIONS IF ANY, ETC..)

PHYSICIAN'S NAME: ________________________________ **SIGNATURE:** ______________________________

OFFICE STAMP: **DATE:** ____________________________________

To be completed by the parent/guardian: I give permission for (name of student) ________________________ to receive the above medication(s) at school according to standard school policy. I will provide medication in the original container, with the current prescription label attached to the school nurse per school policy. I understand that it is my responsibility to provide updated information to the school regarding medication changes, and my contact information. I give permission for the nurse to contact the doctor listed above with any questions or concerns regarding medication administration.

Date: ______________________________ Parent/Guardian Name: ______________________________________

Phone number:______________________ Signature: ____