ARLINGTON ISD MEDICATION REQUEST FORM

The following guidelines apply to medication administered at school:

1. Due to the number of students on campus and the volume of medication distribution involved, medications should be given at home whenever possible.
2. Narcotics cannot be administered
3. Medications may be given by an unlicensed person
4. A parent or guardian should bring the medication to the clinic in case clarification or special directions are needed
5. The first dose of any medication must be given at home to observe for adverse reactions
6. All medications require a parent signature
7. All prescription medications require a physician's signature at all grade levels
8. Over the counter medications require a physician's signature at elementary level.
9. Medications must be kept in the clinic locked cabinet. Do not put a dose in a lunch box or backpack for self- administration
10. Medications must be in the original container and labelled properly in English. Only medications approved for use in the United States will be given.
11. Send only the amount of medication needed at school. No extra medication can be sent home with students. (except inhalers)
12. Unused medication must be picked up by an adult the last day of school or it will be destroyed.
13. Expired medication not picked up by an adult within 30 days will be destroyed.
14. Homeopathic medication, dietary supplement, herbal supplements, and essential oils will only be given in accordance with Arlington ISD Board Policy

By my signature, I request that this medication be given by a school employee. I acknowledge that I will not hold the Arlington ISD, Board of Trustees, and/or District employees liable for damages or injuries resulting from administration of this medication, dietary supplement, herbal supplement, and/or essential oil.

Parent/Guardian Authorization for School Staff to Communicate Health Information: *I authorize the District's designees, including District medical professionals and UAPs, to administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other AISD form requesting for school health services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by HIPPA rules. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information. School- related health services described herein shall not be provided to a student without the required consent of the parent/guardian, as outlined herein.*

Last Name ________________________First Name _____________________ID #__________Grade ________

Parent Signature _____________________________ Date ___________ Mobile Phone __________________

Work Phone _______________ Home Phone ______________ Email _________________________________

INFORMATION BELOW THIS POINT MUST BE COMPLETED IN ENGLISH

Medication Name	Dose	Route	Time(s) to Give

One medication per form

Physician Signature ____ Date ____________

Physician Printed Name _________________________________Phone ______________Fax ___________

Condition for which medication is being given: ____

Allergies/ Special Instructions: ____

For Clinic Use Only

Initial Intake Count _____Signature __________________________Signature __________________________