

**Tuloso-Midway ISD
Health Services
Physician request for long-term administration of medication**

This request is to be effective for the school year _____ - _____

Student's Name _____ DOB _____

Medication _____

Dosage Amount _____ Time to be administered _____

Condition for which medicine is given _____

<p>Inhalant Prescriptions This student is both capable and responsible for self-administering this medication. No _____ Yes – Supervised _____ Yes-Unsupervised _____ This student may carry this medication: No _____ Yes _____</p>

Physician Signature _____ Print Name _____

Address _____

Phone Number _____ Date of request _____

I understand that in accordance with school board policy this medication will be brought to and taken from school only by a parent / guardian. The student will not be in possession of any medication at any time unless he/she has written permission from a physician stating he/she has a condition that requires immediate treatment, such as asthma. This medication will be properly labeled with student's name, dosage, and the time to be administered. This medication will be destroyed if it is not picked up within one week following the stop date or on the last day of classes for the specified school year. In accordance with the Nurse Practice Act, Texas Code Section 217.11 the school nurse has the responsibility to refuse to administer medication that in the nurse's judgment are not in the best interest of the student.

I hereby authorize the exchange of medical information regarding my child's medication. treatment plan between the physician and Tuloso - Midway IDS health services.

Parent/Guardian Signature _____ Date _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Medication orders must be renewed by the attending physician and this release signed by the parent/guardian **annually**.