Rusk Independent School District
203 E. 7th Street
Rusk, Texas 75785

Parent/Physician Request Form for:
Administration of Medication by School Personnel 2020-2021 School Year

Date of Request: ______________________

Student's Name (First and Last): __________________________ Date of Birth: _________ Grade: ______

Medication: ____ Exp. Date: __________ Dosage: _________

Is this the initial dose of a NEW medication that has not been previously administered to the student? YES NO

Time to be Administered: __________________ Med Start Date: __________ Med End Date: __________

Condition for which medication is required: ____

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

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Physicians Name: ________________________________ Phone: _______________ Fax: __________

ALL medication, (including over-the-counter drugs), should be delivered to the office staff/nurse on student's campus. It must be in the original container and properly labeled. Prescription drugs and/or samples from the doctor must be labeled with the students name, dosage to be administered, the prescribing physician's name, date the prescription was filled and the name of the medication. The school will not administer any type of medicine that is not FDA approved. For safety reasons, no exceptions can be made.

***Physician's Signature:** ____

Physician's signature is required to administer any prescribed medication.
Physician's signature is required to administer over-the-counter medications for more than 10 consecutive school days from the date of the original request date.

***Parent/Guardian Signature:** ____

My signature above indicates that I request that RISD staff administer, the medication specified above, to my child. I am giving permission for RISD staff to contact the physician if additional information needed. I agree that I will not hold liable any member of the school staff assisting my child in taking said medication.

Nurse Signature Review: __________________________________ Date: ____________________

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Please choose how you would like the medication handled at the end of the school year?

___ I will pick up the medication from the office staff/nurse myself.
___ Destroy any unused medication.
*ANY unused medication will be destroyed if left within 3 days after the date of which the school year ends.

Signature of Parent/Guardian: _______________________________________ Date: _________________