Jim Ned Health Services
Student Medication Record
(OTC and Short Term Prescription Medications)

Count_____ Parent Initials: _____ Nurse Initials: _____

Signature for initial ID:_____

_____

_____

_____

***Only one medication per form**

Date	Time/#given	Initial	Date	Time/#given	Initial	Date	Time/#given	Initial

Student Name:_____ Teacher: _____ Grade: _____

Medication: _____

Dose: _____ Frequency: _____

Reason for Administering Medication: _____

At the end of the school year remainder of medication pick up:

Parent Signature: _____ Date Picked Up: _____

Request for Administration of: Prescription and Non-Prescription Medication by JIM NED CISD Personnel

Name of Student_____Grade/Teacher _____

Name of Medication: _____ Condition for which medication is to be given: _____

Method of administration at school only: Time: _____ Dosage: _____ Special Instructions:_____

Physician's Name (Print):_____ Physician's Signature: _____

Please initial each statement:

- ____ Parent/Guardian must provide signed documentation from a medical provider for Over the Counter medication to be administered **longer than 3 consecutive days.**
- ____ Medication that is prescribed for "three times a day"/ "every 8 hours" or less **WILL NOT BE** administered at school.
- ____ Medication **may not be scheduled** for other than school hours (Medications scheduled before the first Tardy bell and after the last bell will **NOT** be administered)
- ____ Medication may be administered by a non-medical designee of the principal.
- ____ All medication must be in the **original container** (NO BAGGIES) and will be administered according to prescriber/manufacturer directions.
- **____ ANY and ALL** changes in medication administration **MUST be received in writing or by Telephone Call Directly to the School Nurse from parent/guardian**
- **____ Jim Ned CISD does NOT provide any medication to students**, except emergency medications for severe allergic reactions such as Diphenhydramine HCl and/or Epinephrine (i.e. Benadryl and/or Epi-Pen)

WITH THIS UNDERSTANDING I REQUEST THE STATED MEDICATION BE ADMINISTERED TO THE ABOVE NAMED CHILD.

Parent or Legal Guardian Signature: _____

Date: _____ Phone Number: _____

Revised 3/2023

Notes: