Grand Prairie Independent School District Health Services

MEDICATION FORM FOR SHORT TERM ADMINISTRATION 7-10 DAYS

Please ask your pharmacy to provide an empty labeled bottle for school administration of the medication. Place only the amount needed at school in the bottle.

NAME OF CHILD ____

NAME OF MEDICATION ____

DIAGNOSIS ____

TIME MEDICINE IS TO BE ADMINISTERED ____

DOSAGE TO BE GIVEN ____

POSSIBLE SIDE EFFECTS ____

LAST DATE MEDICINE IS TO BE GIVEN ____

I give my permission for the above medication to be given to my child. I assume all responsibility for any side effects that may occur while my child is receiving this medication. **I understand the first dose must be given at home. First dose given – Date _______________ Time ___________**

SIGNATURE OF PARENT: ____ DATE: _____________________

PRESCRIPTION BOTTLE INFORMATION:

PRESCRIPTION #: _______________________________

DATE FILLED: __________________________________

DOCTOR: _____________________________________

PHARMACY: __________________________________

RECORD OF ADMINISTRATION:		
DATE	TIME	INITIALS

- **According to GPISD guidelines, any unused medication that is not picked up by an adult will be destroyed.**

Signature of Parent/Guardian: ______________________________________ Date: __________________

Home Phone: ______________________ Cell Phone: _____________________ Work Phone: ______________________

Medication-short term Revised 2-18-09