Campus_____ School Fax_____

Northside Independent School District
Health Services Department
Physician Order for Administration of
Medication/Special Procedures by School Personnel

Special health care procedures and medication may be administered at school, by school personnel when such treatment is necessary for school attendance and cannot otherwise be accomplished. After the clinician completes the form, the parent /guardian should bring the completed form along with **non-expired** medication and/or special equipment to the school. **Special forms are available for allergy, asthma, and seizure medications. See https://nisd.net/health-services/ for additional forms. Long term Medication/Special Procedure Forms must be completed annually.**

Prescribed medication/treatments may be administered by a school nurse or a non-health professional designated by the principal. Prescription medications should be brought to school in the original container appropriately labeled by the pharmacy. Parent/Guardian should request that the **pharmacist dispense two (2) bottles of medication**, one for home and one for school. **Clinician's please note: complete orders are required for school dispensing of Over-the-Counter Medications if the medication needs to be administered for a duration longer than the manufacturer's recommendation or on an "as needed" basis.** Over-the-counter medicine must be brought to school in a new, unopened bottle. It is recommended that the parent/guardian take this form to the student's scheduled doctor's visit, to avoid extra clinician office fees.

Student's Name _____ **DOB** _____**ID#**_____

Diagnosis/Condition for which medication administration/procedure is to be performed:

Medication/Procedure	Strength	Dose	Route	Time or Frequency	Precautions, possible untoward reactions
Special Instructions:					

Physician's Signature:_____Date_____
Physician's Name_____Phone #_____
Address_____Fax # _____
Do you want a follow-up report from the nurse? Yes_____ No_____

Parent/Guardian:
We (I), the undersigned, the parent/guardian of (print student name) _____ Date_____
Request that the above medication/procedure be administered to our (my) child.

_____ / _____ Telephone_____ / _____
Parent/Guardian Signature Relationship Home/Cell Business