



CONROE

INDEPENDENT SCHOOL DISTRICT
Health Services

Parent Request for Administration of Medication by School Personnel

SCHOOL YEAR 2024-2025



CONFIDENTIAL

Teacher _____ GR _____

Parent/Guardian email _____

Date Entered in eSchoolPlus _____ Nurse Init. _____

Student Name _____ Student ID _____ DOB _____

As the Parent / Guardian of the above named child, I give my permission for him / her to be given the medication as described below by whomever the principal designates. I understand medication will be handled according to recommended Conroe ISD Policy and Procedure, TEA recommendations and FDA Guidelines.

Printed Name of Parent/Guardian _____ Daytime Phone Number(s) _____

Signature _____ Relationship to Student (Ex. Mom, Step Parent, Etc.) _____ Today's Date _____

Name of Medication		Medication Strength		Dosage	
Route of Administration: <input type="checkbox"/> by mouth <input type="checkbox"/> inhaled <input type="checkbox"/> topical <input type="checkbox"/> eye(s) <input type="checkbox"/> ear(s) <input type="checkbox"/> nasal <input type="checkbox"/> injection: (<input type="checkbox"/> IM <input type="checkbox"/> SQ <input type="checkbox"/> IV) <input type="checkbox"/> rectal				Medication Start Date	Medication End Date
Reason for Taking					
Give Daily Time(s):		OR	Give PRN/As Needed Frequency:		
Special Instructions					
Other Medication(s) Student is Taking					

IF THERE IS A CHANGE IN DOSAGE, AMOUNT, OR TIME, FILL OUT A NEW MEDICATION PERMISSION FORM.

MEDICATION CHECK-IN								
Date Received	Time In	Amount/ Number	Pill Description (Match to Label)	Medication/ RX Expiration	Clinic Staff Signature	Parent/Guardian Signature	Reconciled Date	Nurse Verified
Original								
REFILL(S)								
#1								
#2								
#3								
#4								
#5								
#6								

Physician Name _____ Physician Signature _____ Physician Phone Number _____ Date _____

Med. Pick-Up Date _____ Time _____ By /Sign _____ Relationship _____ Count _____ Staff Initials _____



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Student Name _____ DOB _____ ID# _____

Name of Medication _____ Grade _____

AUGUST					
Date	M	T	W	TH	F
1-2					
5-9					
12-16					
19-23					
26-30					

SEPTEMBER					
Date	M	T	W	TH	F
2-6					
9-13					
16-20					
23-27					
30					

OCTOBER					
Date	M	T	W	TH	F
1-4					
7-11					
14-18					
21-25					
28-31					

NOVEMBER					
Date	M	T	W	TH	F
1					
4-8					
11-15					
18-22					
25-29					

DECEMBER					
Date	M	T	W	TH	F
2-6					
9-13					
16-20					
23-27					
30-31					

JANUARY					
Date	M	T	W	TH	F
1-3					
6-10					
13-17					
20-24					
27-31					

FEBRUARY					
Date	M	T	W	TH	F
3-7					
10-14					
17-21					
24-28					

MARCH					
Date	M	T	W	TH	F
3-7					
10-14					
17-21					
24-28					
31					

APRIL					
Date	M	T	W	TH	F
1-4					
7-11					
14-18					
21-25					
28-30					

MAY					
Date	M	T	W	TH	F
1-2					
5-9					
12-16					
19-23					
26-30					

JUNE					
Date	M	T	W	TH	F
2-6					
9-13					
16-20					
23-27					
30					

SIGNATURES					
Name/Initials	_____				
Name/Initials	_____				
Name/Initials	_____				
Name/Initials	_____				
Name/Initials	_____				

Comments/Notes:
