IOWA PARK CISD
PHYSICIAN/PARENT PRESCRIPTION MEDICATION REQUEST FORM

This section must be completed by the prescribing Physician

Name of Student: _____

Birth Date: _____

Allergies to medication: _____

Medication Prescribed: _____

Dosage: _____

Time and Frequency: _____

Start/Stop Date: _____

_____ _____
Physician's Name Physician's Signature

_____
Physician's Address

Fax Numbers:
Kidwell Elementary-592-2487
Bradford Elementary-592-2059
WF George Middle School-592-2801
Iowa Park High School-592-2583

This section must be completed by the Parent/Guardian

I request the above medication be administered to the above listed student.

_____
Parent/Guardian Name-Print Signature Relationship to Student

_____
Address

_____
Home Phone Cell Work

_____
Emergency Contact and Number

I request this medication to be given to my child during school hours. I fully understand that trained NON-MEDICAL District personnel may administer this medication. I understand that the School District, the Board, and it's employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of a medicine to a student, provided such administration conforms to the requirements of this policy.

You are responsible for picking up any unused medication at the end of the school year. Any medication left at school after the last day will be disposed of.