

**Plano Independent School District
Off Campus Medication Request Form**

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| Student's Last Name | First Name | Drug Allergies | Grade | Teacher |
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Please follow the guidelines below when bringing medication to school:

1. For student safety, all medication should be brought to the sponsoring teacher by the parent. Controlled substances must be counted by the teacher and parent. Medications are not provided by the school.
2. All medication must be in its original, properly labeled container with a written request signed by the parent/guardian.
3. Medication that has expired will not be given. If medication will be destroyed if not picked up by the parent.
4. Nonprescription, homeopathic medication, dietary supplements and herbal supplements will only be given in accordance with Plano ISD Board Policies FFAC(LEGAL) and FFAC(LOCAL).

Medication _____ Dosage _____

Time to be given _____

Number received _____ Parent Initials _____ Witness Initials _____

What is the condition for which this medication is required? _____

Any special instructions/precautions/side effects of this medication for your child? _____

By my signature below, I affirm that it is impossible to schedule the above-mentioned medication at a time other than school hours. I request that this medication be given by a school employee. I acknowledge that I will not hold the Plano ISD, Board of Trustees, and/or District employees liable for damages or injuries resulting from administration of this medication (prescription/nonprescription/ homeopathic/over-the-counter), dietary supplement and/or herbal supplement.

Parent/Guardian Authorization for School Staff to Communicate Health Information

I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my student's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school-related health service such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other PISD form requesting for school health care services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information. School-related health services described herein shall not be provided to a student without the required consent of the parent/guardian, as outlined herein.

Physician Name _____ Phone Number: _____

Parent Signature: _____ Phone Number: _____
Date: _____