DeSoto Independent School District
Health Services
Non-prescription (OTC) Medication Form

According to Texas State Law, Texas Department of State Health Services guidelines, and DISD policy and procedures, all medications that are to be administered at school must comply with the following guidelines:

1. All medication given must be in the original container and NOT expired.
2. The medication has to be FDA approved with dosage information clearly marked on container.
3. All non prescription medications must be accompanied by a dated permission slip signed by the parent/guardian. Please include instructions for the over-the-counter medication.
4. The over-the-counter medication may not be given more than five consecutive school days without physician's order to do so.
5. Medications purchased in a foreign country (for example, Mexico) cannot be given.
6. Medications should not be carried with the student unless there is a physician's order to do so on file in the nurse's office.
7. Parent/guardian must provide medication for the student. DeSoto ISD will NOT provide any over-the-counter medication.

PERMISSION FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION

Student Name:_____ Date of Birth:_____

ID:_____ Grade:_____ School: _____

Name of Medication: _____

Dose to be given at school: _____
(Dose must coincide with label directions. Dosage not coinciding with label requires a prescription medication form.)

When (time/days) to be given at school: _____

Reason for medication: _____

I give permission for my child to receive the above mentioned non-prescription medication. I give my permission to the school nurse or school personnel designated by the principal to administer the above mentioned medication. I give my permission to the school nurse to share information relevant to the above mentioned as she determines appropriate for my child's health and safety. I understand that this permission is valid for the duration of the school year unless the nurse is informed by myself that it has been discontinued and I understand that changes to medication require a new medication form to be completed.

_____	_____	_____
Printed Parent/Guardian Name	Parent/Guardian Signature	Date
_____	_____	
Work Number	Home/Cell Number	

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(For Nurse only) Parent requested discontinuation of medication: _____