Weimar Independent School District

Student Medication Administration During Off Campus Activities

Student Name (Last) (First) (MI)		DOB
Grade	Teacher	

Name of Medication #1			
Dose	Amount to be Given	Route	Time
Reason medication being given			
Name of Medication #2			
Dose	Amount to be Given	Route	Time
Reason medication being given			

Type of Activity:	**Date of Activity:**	
My signature authorizes school personnel to give my child (named above) the medication (specified above) during the off campus activity. I release school personnel from liability in the event an adverse reactions result from taking the medication.		
Parent/Guardian Name	Parent/Guardian Signature	Date
Home Phone	Mobile Phone	Work Phone

DISTRICT USE ONLY			
Initials	**WISD Employee (Please Print)**	**Initials**	**WISD Employee (Please Print)**

Staff Medication Administration Documentation					
Medication #1			**Medication #2**		
Date	**Time**	**Initials**	**Date**	**Time**	**Initials**

Revised 8/2016