

Spring Branch Independent School District
HEALTH SERVICES

Parent's Statement for Student Use of Mosquito Repellent

Student's Name _____ Birthdate _____

School _____ Grade _____

I am requesting that my child be allowed to apply mosquito repellent during school hours as specified below in order to maintain my child's physical health.

Name of Repellent _____

Frequency of Use _____

Lotion Wipes Other _____

Additional information related to this request _____

If there is evidence of a reaction to this medication, please contact me according to the information below or as indicated on my child's emergency procedure card on file at school.

I hereby grant permission for my child to apply mosquito repellent according to the statement given above.

Parent/Guardian Name (Please Print)

Signature of Parent/Guardian

Address

Telephone

Date

Email address _____

Important Information for Parents/Guardians: The repellent listed above must be supplied by the parent/guardian and must be in the original manufacturer's container with an original label containing dosage instructions.