Spring Branch Independent School District

HEALTH SERVICES

Physician's Statement for Administration of Prescription Medication

Student's Name_____ Birthdate_____

School _____ Grade _____

It is necessary that the following medication be administered during school hours as specified below in order to maintain this child's physical health and support school performance.

NAME OF MEDICATION _____ **DOSAGE**_____

TIME _____ **FREQUENCY OF USE** _____

☐ Tablet ☐ Liquid ☐ Drops

☐ Capsule ☐ Inhalation ☐ Ointment

☐ Other (specify) _____

Condition for which medication is prescribed:_____

Medication may cause: _____

Emergency instructions: _____

Medication is regulated by Federal Narcotics Act: Yes_____ No _____

_____ _____

Physician's Name (Please Print) Signature of Physician

_____

Address Telephone Date

I hereby grant permission for the school nurse or other school personnel to administer medication to my child according to the physician's statement given above.

_____ _____

Signature of Parent/Guardian Date

Email Address_____

Important Information for Parents/Guardians:

Medication must be prescribed by a licensed physician and appropriately labeled in the original container by the pharmacy or physician.

This statement must also be completed by a physician and parent/guardian when container labels on non-prescription medications do not specify dosage instructions appropriate for the child's age.

R: 06/10