

Spring Branch Independent School District **HEALTH SERVICES**

Parent's Statement for Administration of Non-Prescription Medication

Student's Name _____ Birthdate _____

School _____ Grade _____

I am requesting that the following medication be administered during school hours as specified below in order to maintain my child's physical health and support school performance.

NAME OF MEDICATION _____ **DOSAGE** _____

TIME _____ **FREQUENCY OF USE** _____

- | | | |
|--|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Tablet | <input type="checkbox"/> Liquid | <input type="checkbox"/> Drops |
| <input type="checkbox"/> Capsule | <input type="checkbox"/> Inhalation | <input type="checkbox"/> Ointment |
| <input type="checkbox"/> Other (specify) _____ | | |

Condition for which medication is requested _____

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.

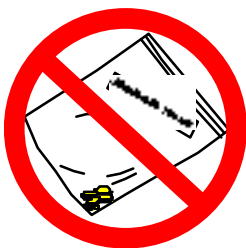
I hereby grant permission for the school nurse or other school personnel to administer medication to my child according to the statement given above.

Parent/Guardian Name (Please Print)

Signature of Parent/Guardian (Original)

Address Telephone Date

Email address



Important Information for Parents/Guardians:

The medication 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.

