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** _____

- ☐ Tablet ☐ Liquid ☐ Drops
- ☐ Capsule ☐ Inhalation ☐ Ointment
- ☐ 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

_____

Address Telephone Date

Email address _____

ALL OVER THE COUNTER MEDICATIONS MUST BE PROVIDED IN THE ORIGINAL CONTAINER WITH THE DOSAGE INSTRUCTION ON THE ORIGINAL LABEL, CLEARLY LEGIBLE.

R: 06/10