



Stafford Municipal School District Medication Permission Form

Name of Student _____

Current Date _____

Grade _____ Teacher _____

As the Parent/Guardian of the above-named child, I give my permission for him/her to be given the medication as described below by whomever the principal designates.

I understand medication will be handled according to recommended SMSD Policy and Procedure, TEA recommendations and FDA Guidelines.

Name of Medication	Amount to be given	Time to be given or frequency	Number in bottle (initial)
1. _____	_____	_____	_____
<i>Reason</i> _____			
2. _____	_____	_____	_____
<i>Reason</i> _____			
3. _____	_____	_____	_____
<i>Reason</i> _____			
4. _____	_____	_____	_____
<i>Reason</i> _____			
5. _____	_____	_____	_____
<i>Reason</i> _____			
6. _____	_____	_____	_____
<i>Reason</i> _____			
7. _____	_____	_____	_____
<i>Reason</i> _____			

Signature of Parent/Guardian _____

Telephone Number _____