# Spring Branch Independent School District

## HEALTH SERVICES

Parent's Statement for Administration of Non-Prescription Medication

Student's Name_________________________________ Date of Birth_________________

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.

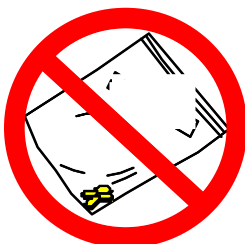
___________________________________ ___________________________________

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: 09/21(ch)