NEW BRAUNFELS ISD MEDICATION PERMISSION

Student: _____ Teacher/ID: _____

Medication: _____

Dose: _____ Time: _____

Special Instructions & Length of Time Needed _____

Reason for Medication: _____

Prescription #_____Pharmacy_____Physician_____

Label Directions:_____Expires:_____

Medication must be in the original container and properly labeled with the name of the medication, name of the student, dosage, and times to be given. All medication (Prescription & Over-The-Counter) will be administered according to the Medication Policy. A physician's order may be required if questions arise or prescription is for long-term use (over 2 weeks). I will notify the school immediately if the health status of my child changes, we change physicians or the medication is changed or cancelled. I authorize the physician to release medical information regarding my child to school health or administrative personnel.

I will not hold liable the NBISD or employees for any adverse reaction, allergic reaction, or side effects my child could have due to taking this medication. I give my permission for the school personnel to give medication to my child at the necessary time.

_____ _____

Date Signature of Parent/Guardian

MedPermN71 (pink) rev.5/2012

NEW BRAUNFELS ISD MEDICATION PERMISSION

Student: _____ Teacher/ID: _____

Medication: _____

Dose: _____ Time: _____

Special Instructions & Length of Time Needed _____

Reason for Medication: _____

Prescription #_____Pharmacy_____Physician_____

Label Directions:_____Expires:_____

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_____ _____

Date Signature of Parent/Guardian

MedPermN71 (pink) rev.5/2012

Student: **Medication:** **Dose:**

Date	Time	Dose	For C.O.	Given by	Date	Time	Dose	For C.O.	Given by

MedPermN71 (pink-back) rev.5/05

Student: **Medication:** **Dose:**

Date	Time	Dose	For C.O.	Given by	Date	Time	Dose	For C.O.	Given by

Med PermN71 (pink-back) rev.5/05