New Braunfels Independent School District

1000 N. Walnut St., New Braunfels, Texas 78130
Phone: _____| Fax: _____
Email: _____ | http://www.nbisd.org

Physician and Parent Authorization for Medication at School

Name of student_____ **Birth date**_____

To Be Completed By The Physician:

1. Condition for which the medication is to be given: _____

_____

2. Name, Strength, Dose, and Time Medication is Given: _____

_____

3. Possible reactions, side effects and special instructions: _____

_____

4. Purpose of Medication: _____

_____

6. Medication to be continued until: _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Address Phone

To Be Completed By Parent or Guardian

We will notify the school immediately if the health status of my child changes, we change physicians, or the medication is changed or canceled. We understand that whenever possible, the medication should be given before or after school hours. Medication must be in the original container and properly labeled with medication name, student name, dosage, and time to be given. All medication (prescription & Over-The-Counter) will be administered according to the Medication Policy.

I request the medication specified by the physician be given to the above named student. 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 authorize the physician to release medical information regarding my child to school health or administrative personnel.

_____ _____
Parent or Guardian Signature Date

_____ _____ _____
Home Phone Work Phone Cell Phone

Please return to