



MIDLAND INDEPENDENT SCHOOL DISTRICT  
HEALTH SERVICES DEPARTMENT

BIN #

# MEDICATION PERMISSION FORM

Dear Parent/Guardian,

According to Midland Independent School District policy, all medications that are to be administered at school must comply with the following guidelines:

1. All medications (prescription or over the counter [OTC]) must be in original container. Medication information must be clearly labeled on the container. Medications will be given as indicated on the label. The medication must be FDA approved.  
**ALL medication MUST be accompanied by a dated permission form signed by the parent/guardian.**
2. The over-the-counter medication must be age appropriate and may not be given more than three consecutive school days without a physician's order to do so.
3. Medications purchased or prescribed in a foreign country (for example, Mexico) cannot be given.
4. No medication is supplied by the school.
5. No controlled medication for pain (ex: Narcotics) or any prescribed medication for behavior control (ex: Ritalin, Concerta, Focalin, or Straterra) will be sent home with students. Whenever possible, these types of medication should be given at home.  
**ALL medications of this type MUST be picked up by a parent or legal guardian.**
6. MISD Health Services **STRONGLY RECOMMENDS** that all medications be delivered to the clinic by a parent or legal guardian. MISD will not accept responsibility for these medications until they are given to the nurse or office staff.

Initial

Student Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ ID#/Grade \_\_\_\_\_  
First name Last name

DATE	MEDICATION	DOSAGE	TIME TO BE GIVEN
Comments			
Comments			
Comments			
Comments			

[ ] At the end of school year, parent/guardian or student (please circle) to collect All medications. \_\_\_\_\_ (Initial)

[ ] Medication not picked up by parent/guardian or student at the end of the school year will be thrown away. \_\_\_\_\_ (Initial)

**I request that the above medications be given to my child as directed. I hereby give permission for the school nurse to contact the prescribing physician with any questions related to the above medications.**

PRINT Parent/Guardian First and Last Name Date Daytime Phone Number

Parent/Guardian Signature Initial