Hillsboro Independent School District Student Health Services

Parental Permit to Administer Medication

Student Name: Last_____ First_____ DOB _____ Age _____ Grade _____

Campus: ☐Daycare ☐FES ☐HES ☐HIS ☐HJH ☐HHS Known Drug Allergies _____

	Scheduled Medication	As Needed Medication #1	As Needed Medication #2
Pharmacy Label	Y N	Y N	Y N
Name of Medication			
Type of Medication	☐Capsules ☐Pills ☐Tablets ☐Liquid ☐Lozenges ☐Topical ☐Nebulizer ☐Inhaler	☐Capsules ☐Pills ☐Tablets ☐Liquid ☐Lozenges ☐Topical ☐Nebulizer ☐Inhaler	☐Capsules ☐Pills ☐Tablets ☐Liquid ☐Lozenges ☐Topical ☐Nebulizer ☐Inhaler
Amount to be Given			
Instructions (including frequency)			
Reason for Medication			
Start Date & Time			
Expiration Date on Package			
Initial Quantity (# pills or ml)			
Prescribing Physician			
Physician Signature (if meets criteria below line)	_____ ☐ Prescription med with no pharmacy label ☐ Non-prescription med to be given routinely ☐ Herbal, dietary, or vitamin supplement	_____ ☐ Prescription med with no pharmacy label ☐ Non-prescription med that exceeds recommended dose on packaging ☐ Herbal supplement	_____ ☐ Prescription med with no pharmacy label ☐ Non-prescription med that exceeds recommended dose on packaging ☐ Herbal supplement
Parent Signature			
Date & Time			

My signature authorizes designated HISD personnel to give the child listed above this medication as directed. I understand that HISD personnel cannot be held responsible in the event of an adverse reaction after appropriate administration of this medication. In such a case, you or another person on the contact list will be notified immediately.

End Date			
Reason to Discontinue			
Quantity picked up			
Parent Signature			

Verified by Nurse			
Entered in Skyward			
Teacher Notified			

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