

NEDERLAND INDEPENDENT SCHOOL DISTRICT

PHYSICIAN/DENTIST REQUEST FOR ADMINISTERING MEDICATION TO STUDENT BY EMPLOYEE

Student's Name _____

Medication _____

Instructions (Dosage, method to be administered, time to be administered at school and duration of the medication period, etc.):

Condition for which medication is to be given: _____

I hereby give permission for an employee of Nederland Independent School District to administer the medication as specified to the above named student.

Date Signed Physician or Dentist

PARENT/LEGAL GUARDIAN REQUEST FOR ADMINISTERING MEDICATION TO STUDENT BY EMPLOYEE

I hereby give permission for an employee of Nederland Independent School District to

administer the above medication as specified by Dr. _____

to my son/daughter _____
Child's Name

I also authorize the School Nurse to communicate with my child's physician as needed in order to ensure safe administration of the medication in school.

Date Signed Parent or Legal Guardian

Note: Students are not permitted to carry any medication or to administer it to themselves unless in writing by the licensed physician or dentist
