



Medical Consent Form for Medication Administration 2026-27

I request that designated Barbers Hill ISD personnel administer the medication listed below to my child according to the physician/prescribing healthcare provider instructions. All medications must be in a current and properly labeled prescription bottle. This form is valid for the 2026-27 school year only.

PHYSICIAN/PRESCRIBING HEALTHCARE PROVIDER AUTHORIZATION MEDICATION INFORMATION BELOW MUST BE COMPLETED BY PHYSICIAN/PROVIDER

Name of Student: _____ DOB: _____ Grade: _____

Condition for which the medication is administered: _____

Name of medication: _____ Dose: _____ Method: _____

Frequency: _____ Medication expiration date: _____

Side effects to be noted/reported: _____

Please check:

____ Duration (dates) of administration: Begin _____ End: _____ (Limit of one school year)

____ Duration of school year (2026-27)

Physician Signature

Print Name

Phone

Date

PARENT/GUARDIAN AUTHORIZATION

By signing below, I acknowledge that:

1. I give permission for the designated Barbers Hill ISD personnel to administer this medication in accordance with the physician's instructions above.
2. I give permission for the school to contact the above health care provider about the administration of this medication.
3. I understand that the school district, Board of Trustees and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medication to a student, provided such administration conforms to the requirements of this policy.
4. Elementary and Intermediate students are **NOT** permitted to transport medication to and from school.
5. Unused medications not picked up within 5 days of being discontinued or at the end of the school year will be disposed of properly.

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date