

Spring Branch Independent School District
HEALTH SERVICES

Parent's Statement for Administration of Non-Prescription Medication

Student's Name _____ Date of Birth _____

School _____ Grade _____

I am requesting that the following medication be administered during school hours as specified below in order to maintain my child's physical health and support school performance.

NAME OF MEDICATION _____ DOSAGE _____

TIME _____ FREQUENCY OF USE _____

- | | | |
|--|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Tablet | <input type="checkbox"/> Liquid | <input type="checkbox"/> Drops |
| <input type="checkbox"/> Capsule | <input type="checkbox"/> Inhalation | <input type="checkbox"/> Ointment |
| <input type="checkbox"/> Other (specify) _____ | | |

Condition for which medication is requested _____

Additional information related to this request _____

If there is evidence of a reaction to this medication, please contact me according to the information below or as indicated on my child's emergency procedure card on file at school.

I hereby grant permission for the school nurse or other school personnel to administer medication to my child according to the statement given above.

Parent/Guardian Name (Please Print)

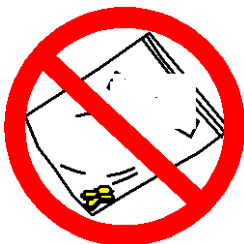
Signature of Parent/Guardian

Address

Telephone

Date

Email address



**ALL OVER THE COUNTER
MEDICATIONS MUST BE
PROVIDED IN THE ORIGINAL
CONTAINER WITH THE
DOSAGE INSTRUCTION ON
THE ORIGINAL LABEL,
CLEARLY LEGIBLE.**