

Spring Branch Independent School District

HEALTH SERVICES

Parent's Statement for Administration of Non-Prescription Medication

Student's Name _____ Birthdate _____

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 _____

- Tablet Liquid Drops
- Capsule Inhalation Ointment
- 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 (Original) _____

Address _____

Telephone _____

Date _____



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