

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.***