

Spring Branch Independent School District
HEALTH SERVICES
Physician's Statement for Administration of Prescription Medication

Student's Name _____ Birthdate _____

School _____ Grade _____

It is necessary that the following medication be administered during school hours as specified below in order to maintain this 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 prescribed: _____

Medication may cause: _____

Emergency instructions: _____

Medication is regulated by Federal Narcotics Act: Yes _____ *No* _____

Physician's Name (Please Print)

Signature of Physician (Original)

Address

Telephone

Date

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

Signature of Parent/Guardian

Date



**Important Information for
Parents/Guardians:**

Medication must be prescribed by a licensed physician and appropriately labeled in the original container by the pharmacy or physician.

This statement must also be completed by a physician and parent/guardian when container labels on non-prescription medications do not specify dosage instructions appropriate for the child's age.

