Lamar Consolidated Independent School District **HF 20**
Rosenberg, Texas

PHYSICIAN'S PERMIT FOR ADMINISTRATION OF MEDICATION IN SCHOOL

(Please Complete for EACH Drug Prescribed)

_____ _____ _____
Student Birth Date School

It is necessary for the above student to receive medication at school for the following reasons:

_____

_____

to be given under the supervision of the school nurse.

_____ _____
Name of Medication Dosage

How often and at what time: _____

Toxic reactions to this drug are: _____

Date to discontinue: _____

Form of medication to be given: tablet _____ pill _____ capsule _____

liquid _____ inhalation _____ other _____

_____ _____
Doctor's Signature Date

PARENTAL PERMIT TO ADMINISTER MEDICATION IN SCHOOL

I request and give permission for the medicine _____

dosage _____ prescribed by Dr. _____ to be

given to _____ as he/she directs under the supervision and the direction of the school nurse. All medication will be properly labeled by a pharmacist when brought to school. By signing this form, I also give my permission for the school to photograph my child for the sole purpose of identification for dispensing this medication.

_____ _____
Parent Signature Date