Spring Branch Independent School District

## HEALTH SERVICES

Physician’s Statement for Administration of Prescription Medication

Student Name Date of Birth

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**

  Tablet  Liquid  Drops

  Capsule  Inhalation  Ointment

  Other (specify)

Condition for which medication is prescribed:

Medication may cause:

Emergency instructions:

***Medication is regulated by Federal Narcotics Act: Yes \_\_\_\_\_\_\_\_\_\_\_ No***

Licensed Health Care Provider’s Name (Please Print) Signature of Licensed Health Care Provider

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

Email Address:

|  |  |  |
| --- | --- | --- |
|  | **Important Information for Parents/Guardians:** Medication must be prescribed by a licensed health care provider and appropriately labeled in the original container by the pharmacy or health care provider.This statement must also be completed by a health care provider and parent/guardian when container labels on non-prescription medications do not specify dosage instructions appropriate for the child’s age. R: 02-13 (jc) |  |