PORT NECHES-GROVES INDEPENDENT SCHOOL DISTRICT

Parent Request for Medication to be Administered

"AS NEEDED" at Campus: _____

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Name of Student: _____ Date _____
Last First Middle

THIS INFORMATION IS CONFIDENTIAL

I hereby authorize school personnel to administer medication which I have sent to school for my child, with the medicine properly marked and supplied in the original container.

NAME OF MEDICATION _____

DOSAGE _____

TIME _____

_____

✍ **Signature of Parent or Guardian**

Note:

1. The school district has received a written request to administer the medication from the parent, legal guardian, or other person having control of the student; and
2. When administering prescription or nonprescription medication, the medication must be in the original container and be properly labeled
3. Please schedule medications around the lunch hour to keep classroom interruptions to a minimum
4. Over-the-counter medications MUST indicate age and/or weight appropriate dosage instructions.
5. This form is for short-term prescription and over-the counter medication use.
6. Long-term medication use requires a Physician Request for Administration of Medication. These are available in the Nurse's Office.