VENUS INDEPENDENT SCHOOL DISTRICT

REQUEST FOR ADMINISTRATION OF

NON-PRESCRIPTION MEDICATION

DURING SCHOOL HOURS BY SCHOOL PERSONNEL

Name of Student_____D.O.B._____

I hereby request and give permission to the school nurse or other authorized personnel to administer the following medication to my child:

Name of Medication_____

Dosage Strength_____

Directions_____

Remarks/Comments_____

Prescribing Physicians Name_____

Physicians Phone Number_____

Physicians Signature_____

MEDICATION MUST BE BROUGHT TO THE SCHOOL IN THE UNOPENED ORIGINAL CONTAINER AS DISPENSED BY THE DRUG STORE OR PHARMACY

If any revisions in the above request occur, a written revised statement must be submitted to the school.

Parent/Guardian Signature_____

Date_____