Friendswood I.S.D. Health Services Parent Request for Administering Medication

Date: Student Gra	de: Allergies:
	el to give my child,,
Dose:	Time:
Reason:	Dates to give medication:
For prescription medication: # of pills sent in by parent/guardian	:# of pills received by school personnel:
Received by:	Witness:
labeled with the child's name, Physician's name must be on p • All over the counter medication the age of 12, i.e. Children's in the age of 1	ion must be age appropriate for children who are under Ibuprofen or Tylenol Jr. Strength. Fill be delivered and picked up by an adult. In the medication, the prescribing physician will be particular arithmetication. Parents will be notified and informed about the
-	Signature of Parent or Guardian

Parent or Guardian Daytime Phone Number

Note: If the medication you request school personnel to administer is deemed excessive or otherwise potentially harmful to the student, medication will not be given and you will be notified of this decision. Injectable medication such as insulin and treatment for allergic reactions will be given only with a physician's written order.