Venus
Independent School District

REQUEST FOR ADMINISTRATION OF **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_____

Prescribing Physician's Name_____

Physician'sNumber_____

Remarks/Comments_____

MEDICATION MUST BE BROUGHT TO THE SCHOOL IN THE UNOPENED ORIGINAL CONTAINER AS DISPENSED BY THE DRUG STORE OR PHARMACY. Labels should clearly list the name of the medication, dosage instructions and date prescribed. If the medication is to be given at home and at school, request the pharmacist to divide the prescription into two containers.

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

Parent/Guardian Signature_____ Date_____