TAYLOR INDEPENDENT SCHOOL DISTRICT

Parent Authorization for Over the Counter Medication

Health Services Department

SCHOOL YEAR: _____

FOR NURSES: Please fill out all fields completely.

Student Name: _____ Grade: _____ Age: _____

Medication Name and Strength	Dose to be Administered	Time(s) to be given at school	Dates to be administered	Reason for Administration

FOR PARENTS/GUARDIANS: Please acknowledge the following and sign.

In order to administer any over the counter medication, Taylor ISD requires parent/guardian written authorization. The medication must be provided by the parent, in the original, unopened and properly labeled container and cannot be expired. The first dose of this medication may not be given at school.

- I request that the above medication be given during school hours, as prescribed
- I request that this medication also be given on field trips, if needed, as prescribed
- I will notify the school of any change in the medication
- I give permission for the school nurse to communicate with the student's teachers about the student's health condition and actions of the medication
- I give permission for the medication to be administered by personnel designated by the Principal
- I understand that the above information can only be used for the current school year and a new form will need to be obtained for each year

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

FOR SCHOOL USE ONLY

Received by: (Print Name) _____ Date: _____