Highland Park Independent School District

STUDENT MEDICATION FORM

ALLERGIES: ____________________________ School Year: ______________

Student: _______________________________ Grade/Teacher: ____________

Age: ______________ Phone: _____________________

I request the School Nurse, Principal, or his/her designee to administer the medication listed below to my child. I grant permission for the school nurse to contact the prescribing physician as needed. I release this individual and the school (Highland Park Independent School District) from liability due to any allergic or adverse reaction to this drug.

IMPORTANT NOTE:

1. Medication must be in its **original, properly labeled** container and up-to-date by law.
2. The school does not provide over-the-counter medications such as Tylenol, Motrin, or cough syrup, etc. *These need to be supplied by the parent or guardian.*

Medication: ____

1. Amount to be given: ____
2. Time(s) to be given: ____
3. Duration (please check): ❑ All Year _____ Days ❑ As needed

Special instructions: ____

Parent Signature: ______________________________________ Date: _______

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