Highland Park Independent School District

**STUDENT MEDICATION FORM**

**ALLERGIES:** _____ School Year: _____

**Student:** _____ Grade/Teacher: _____

D.O.B._____ Phone: _____

I request the School Nurse, Secretary, 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:

Medication must be in its **original, properly labeled** container and up-to-date by law. 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.* ***Medications must be picked up at the end of the school year or they will be discarded. School clinics may not store medication during the summer.***

**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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