

**FORT BEND INDEPENDENT SCHOOL DISTRICT**  
**Parent-Physician Permit to Administer Medication at School**

Student \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_

Teacher (for elementary use) \_\_\_\_\_ Allergies \_\_\_\_\_

|                                                                                                |                |            |
|------------------------------------------------------------------------------------------------|----------------|------------|
| Medication _____<br><small><i>Include brand and generic name</i></small>                       | Strength _____ | Dose _____ |
| Frequency _____ As needed _____ or Scheduled time: _____                                       |                |            |
| Start date to be given: _____ End date to be given: _____ (Valid for current school year only) |                |            |
| Number of pills or tablets _____ Expiration date of medication _____                           |                |            |
| Reason student is receiving medication: _____                                                  |                |            |
| Possible reactions or restrictions: _____                                                      |                |            |

I give permission for Fort Bend ISD personnel to give the above medication. The school nurse has my permission to consult Dr. \_\_\_\_\_ with questions regarding this medication. The physician's signature is required in the following circumstances: all prescription medications, all over the counter (OTC) medications, the medication is for life-threatening conditions, or at the school nurse's discretion.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Home Phone # \_\_\_\_\_ Daytime phone # \_\_\_\_\_

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Comments: \_\_\_\_\_

\_\_\_\_\_

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|                                |                   |             |
|--------------------------------|-------------------|-------------|
| Physician's Name (Print) _____ | Telephone # _____ | Fax # _____ |
|--------------------------------|-------------------|-------------|

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|                                           |            |
|-------------------------------------------|------------|
| Physician's signature (if required) _____ | Date _____ |
|-------------------------------------------|------------|

FORT BEND INDEPENDENT SCHOOL DISTRICT

School Health Services

Medication Count Worksheet

Student Name \_\_\_\_\_

Medication \_\_\_\_\_

| Date | Qty received | Qty returned | Signature #1<br>parent/guardian | Signature #2<br>Clinic staff |
|------|--------------|--------------|---------------------------------|------------------------------|
|      |              |              |                                 |                              |
|      |              |              |                                 |                              |
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|      |              |              |                                 |                              |
|      |              |              |                                 |                              |

Medication Administration

| Date | Time | Dose<br>Administered | Name of Administering<br>personnel | Signature of Administering<br>personnel |
|------|------|----------------------|------------------------------------|-----------------------------------------|
|      |      |                      |                                    |                                         |
|      |      |                      |                                    |                                         |
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Notes: