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

Student _____ Grade _____ DOB _____

Teacher (for elementary use) _____ Allergies _____

Medication_____ 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, the medication is to be given for more than 15 days, the medication is for life-threatening conditions or at the school nurse's discretion.

Parent/Guardian Signature_____ Date_____

Home Phone # _____ Daytime phone # _____

Comments:_____

_____

_____

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

_____ _____
Physician's signature (if required) Date