

**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 \_\_\_\_\_