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

Student ____ Grade ______ DOB _______________

Teacher (for elementary use) _____________________ Allergies ____________________________________

Medication______________________________ Strength _____________ Dose_____________________
Include brand and generic name

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 # ______________________________

Comments:____

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____ ____________________ ____________________
Physician's Name (Print) Telephone # Fax #

____ ____________________
Physician's signature (Required) Date

Med consent
Updated 08/2024

FORT BEND INDEPENDENT SCHOOL DISTRICT

School Health Services

Medication Count Worksheet

Student Name____

Medication____

Date	Qty received	Qty returned	Signature #1 parent/guardian	Signature #2 Clinic staff

Medication Administration

Date	Time	Dose Administered	Name of Administering personnel	Signature of Administering personnel

Notes: