

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

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

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

Medication _____ <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 # \_\_\_\_\_

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

Physician's Name (Print) \_\_\_\_\_ Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

Physician's signature (if required) \_\_\_\_\_ Date \_\_\_\_\_