

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

Student _____ Grade _____ DOB _____

Camp Name _____ Allergies _____

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| 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 Extended Learning Program 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 Program's discretion.

Parent/Guardian Signature _____ Date _____

Home Phone # _____ Daytime phone # _____

Comments: _____

Physician's Name (Print) Telephone # Fax #

Physician's signature (if required) Date