

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

Student _____ Grade ____ DOB _____ Teacher _____

Medication _____ Dosage _____

Time to be given _____ Dates to be given _____

Reason student is receiving medication _____

I would like school personnel to give the above medication as directed.

If medication is to be given more than 15 consecutive days,

Dr. _____ will authorize administration.

Parent/Guardian Signature _____ Date _____

Home phone (____) _____ Daytime phone (____) _____

Comments: _____

Physician's Name (print) Telephone # Fax phone #

Physician's signature Date