DENISON INDEPENDENT SCHOOL DISTRICT

MEDICATION PERMISSION FORM

STUDENT'S FULL NAME:____

DATE OF BIRTH:_______________TEACHER:________________________________GRADE:_________________

NAME OF MEDICATION:____

TIME TO BE GIVEN:_______________________________ ROUTE TO BE GIVEN:___________________________

AMOUNT TO BE GIVEN:____

REASON YOUR CHILD NEEDS THIS MEDICATION:____

AUTHORIZATION TO RELEASE INFORMATION: I request the administration of the above medication to my child by DISD personnel. I understand my signature gives the physician my consent to release information to DISD personnel and releases the district from liability due to any allergic reaction or side effects.

RESCRIBING PHYSICIAN:________________________________Phone________________FAX:________________

PARENT/GUARDIAN SIGNATURE:____DATE:_______________

NUMBER PARENT/GUARDIAN CAN BE REACHED DURING SCHOOL HOURS:______________________________

OVER THE COUNTER MEDICATIONS WILL ONLY BE GIVEN FOR 10 DAYS. IF OTC MEDICATION IS NEEDED FOR MORE THAN 10 DAYS A SIGNED DOCTORS NOTE WILL BE REQUIRED.
(This is the Parent's Responsibility to obtain doctors note)

NAME OF MEDICATION:____DOSAGE:___________________

TIME TO BE GIVEN AT SCHOOL:______________________________________ ROUTE:_____________________

REASON TO BE GIVEN AT SCHOOL:____

LENGTH OF TIME TO BE GIVEN:________________________________RESTRICTIONS?_____________________

ADVERSE DRUG REACTION(S)____

PHYSICIAN SIGNATURE____DATE:____________________

************IT IS AGAINST DISD POLICY TO SEND MEDICATION HOME WITH STUDENTS************

Revised 08/29/11