

Highland Park Independent School District
STUDENT MEDICATION FORM

ALLERGIES: _____ School Year: _____

Student: _____ Grade/Teacher: _____

D.O.B. _____ Phone: _____

I request the School Nurse, Secretary, Principal, or his/her designee to administer the medication listed below to my child. I grant permission for the school nurse to contact the prescribing physician as needed. I release this individual and the school (Highland Park Independent School District) from liability due to any allergic or adverse reaction to this drug.

IMPORTANT NOTE:

Medication must be in its **original, properly labeled** container and up-to-date by law. The school does not provide over-the-counter medications such as Tylenol, Motrin, or cough syrup, etc. *These need to be supplied by the parent or guardian.*

Medication: _____

1. Amount to be given: _____

2. Time(s) to be given: _____

3. Duration (please check): All Year _____ Days As needed

Special instructions: _____

Parent Signature: _____ Date: _____

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