



Prescription Medication Form

Please return this form to the school nurse at nurse@stmarkhouston.org or fax 713 468 6735.

I request and hereby give permission to school personnel to give the prescription medication to my child named below as requested by the physician.

Child's Name

Date of Birth

Telephone Number

Parent Signature

Physician's Statement

Child's Name

Date

In order that this school child remain in optimum health and to help maintain maximum school performance, it is necessary that the following medication be given during school hours.

Name of Medication

Dosage to be given (amount)

Prescription Number (School Nurse)

Expiration Date (School Nurse)

Form of medication: tablet capsule liquid inhalation injection

How often and what times

Purpose

Side effects:

Remarks:

Printed name of physician

Physician's signature

