BROCK INDEPENDENT SCHOOL DISTRICT

MEDICATION PERMIT FORM

If the administering of medication at school is necessary, the frequency of the administration should be adjusted so that only one dose will be given at school. The first initial dose of any medication will not be given at school due to the possibility of allergic reactions or other side effects.

1. All prescription and non-prescription medication must be
   a. Provided by the parent and accompanied by the completed permission slip below
   b. In its original container and properly labeled. **(NO MEDS ACCEPTED IN BAGGIES)**
   c. Given according to the label directions
2. "Sample" medications must be labeled with the students name and accompanied with a written and signed doctor's statement as to the frequency and dosage of administration.
3. We recommend that Students with INHALERS that must be kept with them must provide the school with another inhaler in case of loss or emergency.
4. Alternative medications, dietary supplements, and herbal medication must be accompanied by this permit and informational sheets which include correct dosage, ingredients, actions and side effects or they cannot be given by school personnel.
5. The parent is responsible for the transportation of the medication to and from the school clinic. The school district cannot assume any responsibility for medication carried to school by the student. Medicine not picked up at the end of the school year will be discarded. Upper level students may transport medication home at the end of the school year with a permission slip from the parent or guardian.
6. For the safety of the students, non-prescription medication that is to be given on an ongoing basis (i.e for 10 dosages or 10 days, whichever is greater) will need a written and signed doctor's statement as to frequency and dosage of administration.

PARENTAL PERMISSION FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

To the Nurse or Designated School Employee of Brock ISD DATE: _____

STUDENT _____ DOB: _____

In order for the above student to remain in school, it is necessary that the following medication be given during school hours as directed.

NAME OF MEDICATION:_____

DIRECTIONS: _____

NAME OF MEDICATION:_____

DIRECTIONS: _____

I hereby request that the medication specified above be administered to the above name student

SIGNATURE OF PARENT/GUARDIAN:_____