

# Fayetteville Independent School District Health Services Department

**This form should be used ONLY when sending medication to school.**

If it is necessary for your child to receive medication during school hours, the school MUST RECEIVE A WRITTEN REQUEST TO ADMINISTER the medication from the parent, legal guardian, or other person having legal control of the student.

**All medication must be in the original container and be properly labeled. Medicine from a doctor must be in a prescription bottle or accompanied by a note from the physician stating how to administer. Loose, unmarked medication WILL BE DISPOSED OF.**

**Inhalers and daily medication that are prescription must be accompanied by a physician order.**

***Please Notice: Fayetteville ISD does not provide any type of medication.***

## Medication Permission Form

Student \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Medication \_\_\_\_\_ Dose/Amt. \_\_\_\_\_ Time \_\_\_\_\_

Medication \_\_\_\_\_ Dose/Amt. \_\_\_\_\_ Time \_\_\_\_\_

Medication \_\_\_\_\_ Dose/Amt. \_\_\_\_\_ Time \_\_\_\_\_

Medication \_\_\_\_\_ Dose/Amt. \_\_\_\_\_ Time \_\_\_\_\_

How long is the student to receive this medicine at school?

Daily \_\_\_\_\_ # Days \_\_\_\_\_ #Weeks \_\_\_\_\_ As Needed \_\_\_\_\_ Other \_\_\_\_\_

Reason student is receiving medication (cough, pain, headache, ect.) \_\_\_\_\_

**I give Fayetteville Independent School District Permission to administer the above named medications as directed.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

### **Prescription Medication Only:**

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Phone Number \_\_\_\_\_