

**CLEAR CREEK INDEPENDENT SCHOOL DISTRICT
CLEAR BROOK HIGH SCHOOL**

PARENTAL CONSENT FOR MEDICATION ADMINISTRATION

The school nurse has permission to administer the following medication to my child,

Student name _____

Name of medication _____

Dose to be given _____

Date to be given _____

2007-2008 school year: yes _____ no _____

Grade _____

Parent's signature _____

**Clear Creek Independent School District
Clear Brook High School
4607 FM 2351
Friendswood, Texas 77546
281-284-2113
Fax 281-284-2209**

Physician's request for administration of medication at school
To promote optimum health and maintain school performance, it is necessary that this medication be administered during the school day.

Student: _____ **Grade** _____

Diagnosis or reason for medication: _____

Medication: _____

Dose: _____

Time/Frequency: _____

Potential Side Effects: _____

Remarks: _____

Signature of Physician: _____

Print/type name of physician: _____

Telephone: _____ **Date:** _____

Parent/Guardian request for administration of medication at school

This is permission to administer medication during the school day. Medication will be provided to the school in the properly labeled container (either prescription or manufacturer's container). Authorization forms must be provided for each school year or anytime the dose or directions change. A physician's signature and parent's signature are required on all prescription medications over 10 days(ones given daily).

Signature of parent/guardian: _____