

**Channelview ISD
828 Sheldon Rd.
CHANNELVIEW, TX 77530
281-452-8002**

MEDICATION PERMISSION REQUEST FORM

When possible, students should take medications before coming to school and/or after leaving school. **Medicine given at school should only be necessary if instructions require four or more doses per day, or if there is a doctor's order requiring medicine to be given at a specific time during the school day. The medicine must be in the original container for the specific student and include the following information: current date, student's name, specific instructions (dosage & time), name of medicine, and doctor's name.** Refer to the "Student Handbook" for further information.

Name of Student: _____ Date of Birth: _____

Student ID number: _____ Grade: _____ Teacher: _____

Name of School Nurse: _____ Phone#: _____ Fax#: _____

To Be Completed by Physician

Condition Requiring Medication _____

Allergies to Medications: _____

*******Dosage Instructions on the Medication Label Must Match the Dosage Instructions on the Medication Permission Request Form.**

Name of medication _____

Specific time(s) and dose(s) to be given at school _____

Start Date: ____/____/____ End Date: ____/____/____

Are there any restrictions? ____ yes ____ no If yes, what and how long? _____

Printed Name of Physician Signature of Physician Phone # Fax #

To Be Completed By Parent

Rev.4/19

I give permission for my child, _____, to receive the above medication as directed.

Date Parent/Guardian Signature Printed Name of Parent/Guardian

Daytime Telephone # _____