Henrietta Independent School District

Non-Prescription Medication Authorization

Date of Request: _____

Name of Student: _____ Birthdate: _____

School: _____ Grade: _____

Home Phone: _____Emergency Phone: _____

Medication Allergies: _____

Food/Environmental Allergies: _____

Date medication to be discontinued: _____

Medication must be in original properly labeled container

Name of medication: _____

Amount to be given (must agree with package directions, otherwise a physician's order is required):

_____

Frequency of administration (must agree with package directions, otherwise a physician's order is required):

I request this medication to be administered to my child during school hours. I fully understand that trained NON-MEDICAL District personnel may administer the medication. I understand that the School District, the Board and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medicine to a student provided such administration conforms to the requirements of this policy.

_____

Signature of Parent/Guardian