

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 is to be discontinued: _____

Medication must be in an 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 given 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 it's 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

Day time phone number