FBISD MEDICATION RELEASE FORM

DATE: ___________

STUDENT'S NAME:______________________**ID#/TEACHER**_________________________

I hereby request that the medication, ordered by a Health Care Provider, or Over-The-Counter (OTC) medication provided by me, for my child, be administered by school personnel. I understand that I must supply the school with the prescribed/OTC medication in the **original container** dispensed and properly labeled. Only FDA approved medications prescribed in the state of **TEXAS** will be accepted. Medications will not be sent on Field Trips unless requested by a parent/guardian**. I give consent for the school nurse to contact the Health Care Provider to discuss this medication. I understand that this medication will be destroyed if it is not picked up by the last day of school.**

Prescribing Physician: ______________________ Office #: ________________________________

Name of Medication: ____

Dosage: __________________________________ at ______________________________________
(How much/many) (Time)

Starting Date: ____________________________ Ending Date: _______________________________

Name of Medication: ____

Dosage: __________________________________ at ______________________________________
(How much/many) (Time)

Starting Date: ____________________________ Ending Date: _______________________________

Name of Medication: ____

Dosage: __________________________________ at ______________________________________
(How much/many) (Time)

Starting Date: ____________________________ Ending Date: _______________________________

Parent Signature: ____

Print Name: ____

Phone Number: ____

FB3300-35R15