Round Top – Carmine I.S.D.
Permission to Administer Prescription or Non-Prescription Medication
at School for 15 Days or Less

Student Name: Last		First		MI	Age
Grade	Teacher				

☐ PRESCRIPTION		☐ NON-PRESCRIPTION	
Name of Drug		Name of Drug	
Time or Frequency to be Given		Time or Frequency to be Given	
Amount to be Given		Amount to be Given	
Reason Medication to be Given:		Reason Medication to be Given:	
Number of Tablets:	Pills:	Capsules:	Other
SEND ONLY THE AMOUNT STUDENT NEEDS TO TAKE AT SCHOOL IN PROPERLY LABELED, ORIGINAL CONTAINER, SO THAT STUDENT WILL NOT BE REQUIRED TO CARRY MEDICATION BACK AND FORTH FROM HOME TO SCHOOL ON A DAILY BASIS.			
☐ My child may transport this medication to and from school		☐ I will transport this medication to and from school	
Parent/Guardian Signature:		Date:	
Home Telephone: ( )		Work Telephone: ( )	

Parent/Guardian: Please complete this form and return with the student's medication *in the original container* should it become necessary for your child to receive medication at school. This form is for medications that will be given for 2 weeks or less.