Round Top – Carmine I.S.D.
Physician – Parent Permit to Administer Prescription or
Non-Prescription Medication at School for More Than 15 Days

Student Name: Last	First	MI	Age

Grade	Teacher

Reason Student Receiving Medication:

Name of Medication:

Dosage:	Date to D/C:

Possible Toxic Reactions:

Form of Medication: ☐ Tablet ☐ Pill ☐ Capsule ☐ Liquid ☐ Inhalant	☐ Other

Feedback Requested:	How Often:

Physician Signature:	Date:	Telephone:

Physician's Printed Name:

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.

This is the school's permission to give:	The above medication as prescribed by :

☐ 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.* This form is for medications to be given for longer than two weeks, or as needed, throughout the school year. Please note – a physician's signature is required.