

Randolph Field Independent School District
Post Office Box 2217
Universal City, Texas 78148-1217

Medication Permission Form

Student's Name _____ Date of Birth _____

Grade/Teacher _____ Condition _____

Start Date _____ End Date _____

Medication name / Dosage / Times to be administered / Instructions

1. _____

2. _____

3. _____

Medication allergies: _____

Please list all other medications taken at home: _____

We are delivering to you the prescription medication listed above in the original container and properly labeled with the patient's name, name of the medication, dosage and times to be given. We request this medication be given to our child in accordance with the above written instructions. We fully understand that you are under no obligation to administer the medication but will do so as our agent acting in our behalf. We agree to hold you, the school, its offices and employees harmless in administering the medications pursuant to the physicians written instructions and our instructions. We agree to notify you promptly when it is no longer necessary to administer this medication.

_____	_____	_____	_____
Name of Mother	Home phone	Work phone	Cell phone

_____	_____	_____	_____
Name of Father	Home phone	Work phone	Cell phone

***Parent Signature** _____ **Date** _____