

CUERO INDEPENDENT SCHOOL DISTRICT

Health Services

Parent request for Medication Administration

I request that the designated school employee administer the following medication to my child during school hours.

STUDENT _____

TEACHER _____

MEDICATION _____

DOSAGE _____

PHYSICIAN _____

PRESCRIPTION # _____

ALLERGIES _____

Note: Prescription medication must have a pharmacy label with the prescription number, the child's name, physician's name, and directions. Over-the-counter medications must be brought in the original containers with directions specific to the child's age.

Signature Parent/Guardian

Date