CONROE INDEPENDENT SCHOOL DISTRICT
Committed to Excellence

Medication Permission

Confidential

Name of Student _____

Current Date _____

Grade _____ Teacher _____

As the Parent/Guardian of the above-named child, I give my permission for him/her to be given the medication as described below by whomever the principal designates.

I understand medication will be handled according to recommended CISD Policy and Procedure, TEA recommendations and FDA Guidelines.

	Name of Medication	Amount to be given	Time to be given or frequency	Number in bottle (initial)
1.	_____	_____	_____	_____
	Reason _____			
2.	_____	_____	_____	_____
	Reason _____			
3.	_____	_____	_____	_____
	Reason _____			
4.	_____	_____	_____	_____
	Reason _____			
5.	_____	_____	_____	_____
	Reason _____			
6.	_____	_____	_____	_____
	Reason _____			
7.	_____	_____	_____	_____
	Reason _____			

Signature of Parent/Guardian _____

Telephone Number _____