**MIDLAND INDEPENDENT SCHOOL DISTRICT**
**HEALTH SERVICES DEPARTMENT**

**BIN #**

# MEDICATION PERMISSION FORM

Dear Parent/Guardian,

**According to Midland Independent School District policy, all medications that are to be administered at school must comply with the following guidelines:**

1. All medications (prescription or over the counter [OTC]) must be in original container. Medication information must be clearly labeled on the container. Medications will be given as indicated on the label. The medication must be FDA approved. **ALL medication MUST be accompanied by a dated permission form signed by the parent/guardian.**
2. The over-the-counter medication must be age appropriate and may not be given more than three consecutive school days without a physician's order to do so.
3. Medications purchased or prescribed in a foreign country (for example, Mexico) cannot be given.
4. No medication is supplied by the school.
5. _____ Initial No controlled medication for pain (ex: Narcotics) or any prescribed medication for behavior control (ex: Ritalin, Concerta, Focalin, or Straterra) will be sent home with students. Whenever possible, these types of medication should be given at home. **ALL medications of this type MUST be picked up by a parent or legal guardian.**
6. MISD Health Services **STRONGLY RECOMMENDS** that all medications be delivered to the clinic by a parent or legal guardian. MISD will not accept responsibility for these medications until they are given to the nurse or office staff.

**Student Name:** _____ **D.O.B.**_____ **ID#/Grade**_____
First name Last name

| DATE | MEDICATION | DOSAGE | TIME TO BE GIVEN |
|---|---|---|---|
| | | | |
| Comments | | | |
| | | | |
| Comments | | | |
| | | | |
| Comments | | | |
| | | | |
| Comments | | | |

[ ] At the end of school year, parent/guardian or student **(please circle)** to collect All medications. _____ (Initial)

[ ] Medication not picked up by parent/guardian or student at the end of the school year will be thrown away. _____ (Initial)

***I request that the above medications be given to my child as directed. I hereby give permission for the school nurse to contact the prescribing physician with any questions related to the above medications.***

_____ _____ _____
**PRINT Parent/Guardian First and Last Name** **Date** **Daytime Phone Number**

_____ _____
**Parent/Guardian Signature** **Initial**

Rev. 08/05/16