



# New Braunfels Independent School District

1000 N. Walnut St., New Braunfels, Texas 78130  
Phone: 830.643.5700 | Fax: 830.643.5701  
Email: nurse@nbsid.org | http://www.nbsid.org

## Physician and Parent Authorization for Medication at School

Name of student \_\_\_\_\_ Birth date \_\_\_\_\_

### To Be Completed By The Physician:

- 1. Condition for which the medication is to be given: \_\_\_\_\_
- 2. Name, Strength, Dose, and Time Medication is Given: \_\_\_\_\_
- 3. Possible reactions, side effects and special instructions: \_\_\_\_\_
- 4. Purpose of Medication: \_\_\_\_\_
- 6. Medication to be continued until: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Address \_\_\_\_\_  
Phone

### To Be Completed By Parent or Guardian

We will notify the school immediately if the health status of my child changes, we change physicians, or the medication is changed or cancelled. We understand that whenever possible, the medication should be given before or after school hours. Medication must be in the original container and properly labeled with medication name, student name, dosage, and time to be given. All medication (prescription & Over-The-Counter) will be administered according to the Medication Policy.

I request the medication specified by the physician be given to the above named student. I will not hold liable the NBISD or employees for any adverse reaction, allergic reaction, or side effects my child could have due to taking this medication. I authorize the physician to release medical information regarding my child to school health or administrative personnel.

\_\_\_\_\_  
Parent or Guardian Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone

Please return to