Anna Independent School District

Parent Permission Form: Over the Counter Medications

This form is valid for one school year

Student Name:_____DOB:_____Drug Allergies:_____

Condition/s for medication to be given at school_____

Medication	Expiration date	Dosage in mgs	Time/frequency/route	Indications to give
1.				
2.				
3.				

List any special instructions/precautions/side effects of medications: _____

_____

_____

Has your child ever had this medication before? _____

****Anna ISD will not administer medications with aspirin products in them, without a physician signature. In addition, any over the counter medication administered more than five days consecutively will require a physician signature. Only medications provided by parent/guardian will be administered.*

I authorize Anna ISD to administer above medication/s to my child and understand that a designated employee may administer medications if the nurse is unavailable. I also authorize the AISD nurse to contact physician to clarify medication orders and discuss effects and conditions, if needed. Medication not picked up at the end of the school year will be destroyed.

Parent Signature:_____ Daytime phone:_____