LUFKIN ISD HEALTH SERVICES

Jan Fulbright ~ Director of Health Services
936.633.7264

OVER THE COUNTER MEDICATION AUTHORIZATION

I give my permission for LISD to give my child: _____

The following medication: _____

DOSAGE:

_____

WHEN TO GIVE:_____

START DATE: _____ End Date:_____

******IMPORTANT***End date 10 school days after start day, all unused said medication will be disposed of by the nurse after the end date.***

Reason for medication: _____

I hereby release Lufkin ISD from liability to allergy or reaction to said medication.

_____

Parent or Guardian Signature

_____

Date

MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER WITH LABEL INTACT. The label must not be altered. Parent directions must match label directions. The dosage must be appropriate for your child's age.

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