JUDSON INDEPENDENT SCHOOL DISTRICT

TO BE FILLED OUT FOR ALL CHILDREN RECEIVING MEDICATION THAT IS TO BE ADMINISTERED WHILE THE CHILD IS IN SCHOOL.

I REQUEST THAT MY CHILD____
BE GIVEN THE FOLLOWING MEDICATION WHILE IN SCHOOL.

GRADE_______TEACHER_____________________________ DOB________________

NAME OF MEDICATION: ____Tylenol_________________________

TIME GIVEN: _______PRN_______________________________________

AMOUNT OF DOSAGE: _______Age appropriate dosage_________________________

Circle YES or No if want given

LENGTH OF TIME TO BE GIVEN: _______School year________________

MEDICATION MUST BE BROUGHT IN THE ORIGINAL PRESCRIPTION CONTAINER WITH THE FOLLOWING INFORMATION:

____ ____

PARENT'S SIGNATURE DATE

____

PHONE

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