Henrietta Independent School District

Non-Prescription Medication Authorization

Date of Request: ______________________

Name of Student: _____________________ Birthdate: _____________

School: ______________________________ Grade: ________________

Home Phone: ___________________Emergency Phone: ____________

Medication Allergies: ____

Food/Environmental Allergies: _________________________________

Date medication to be discontinued: ____________________________

Medication must be in original properly labeled container

Name of medication: ______________________________________

Amount to be given (must agree with package directions, otherwise a physician's order is required):

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Frequency of administration (must agree with package directions, otherwise a physician's order is required):

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I request this medication to be administered to my child during school hours. I fully understand that trained NON-MEDICAL District personnel may administer the medication. I understand that the School District, the Board and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medicine to a student provided such administration conforms to the requirements of this policy.

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Signature of Parent/Guardian