Gainesville ISD
Authorization to Administer Medication

Name of Student______________________________ Date_________________

Teacher_____________________________________ Grade________________

PHYSICIAN TO COMPLETE THIS SECTION
(unless a nonprescription medication or to be given less than 10 school days)

Prescribed Medication/Treatment:	Dosage:
	Time(s) of Administration:
Diagnosis:	Route of Administration:
Date of Request:	Termination Date of Medication:
Precautions/Restrictions related to medication:	
Medication Allergies:	Food/Environmental Allergies:
Physician Name (please print):	Physician Phone Number:
	Physician Fax Number:

Physician's Signature:____

PARENT TO COMPLETE THIS SECTION

I, the parent/legal guardian of ____________________________________,
Name of Student

hereby request that the above medication be given as directed. I hereby release GISD from all legal responsibility or liability that may arise, pursuant to this request for administration of medication for my child. I give permission for Gainesville ISD staff to contact the physician for additional information or clarification, if needed. My child also has my permission to transport this medication to the school nurse and home from school releasing GISD from any liability that may occur.

Parent/Guardian Signature __________________________________ Date_____________

Phone: Home__________________ Cell____________________ Work________________

My child has permission to carry their rescue inhaler and /or Epi-pen.________(INITIALS)