West Sabine Independent School District

Superintendent	High School Principal	Elementary Principal
Cristal Joslin	Colleen Conn	Debbie Lane
409-584-2655	409-584-2525	409-584-2205
214-534-4872 (cell)	Fax: 409-584-2695	Fax: 409-584-3096

Parent Consent to Administer **Over-the-Counter Medication** in School

(Medication must be in original container and properly labeled)

Date:_____

Student Name:_____ Age:_____

Medication: _____Exp. Date: _____
Dosage: _____Route:_____ Frequency:_____
Specific times to be given at school as needed for:_____

Medication: _____Exp. Date: _____
Dosage: _____Route:_____ Frequency:_____
Specific times to be given at school as needed for:_____

Medication: _____Exp. Date: _____
Dosage: _____Route:_____ Frequency:_____
Specific times to be given at school as needed for:_____

ALL PRESCRIPTIONS AND OVER-THE-COUNTER MEDICINE TO BE PROVIDED BY PARENT.

I authorize my child's school nurse or delegate to administer the above medication(s) to my child during the school day. I agree to hold West Sabine ISD, its employees, and delegates who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication(s) at school. Also in the event this medication is stopped or any changes are made in the administration of this medication, I will immediately notify the school. If the discontinued medication is not picked up by me within the school year, I give permission for it to be discarded/destroyed. I understand that expired medication will not be administered, but will be discarded/destroyed. I also understand that I should supply all medication and will provide the appropriate dosage for my child's age, unless otherwise indicated with a physician's signature.

_____ _____ _____ _____

Parent/Guardian Signature Relationship Date Reviewed by Nurse

Per FFAC (local) and FFAC (legal) WSISD Policy

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Parent Consent to Administer **Prescription Medication** in School

(Medication must be in original, labeled containers)

Date:_____

Student's Name:_____ Age:_____

Medication: _____Exp. Date: _____
Dosage: _____Route:_____ Frequency:_____
Specific times to be given at school as needed for:_____

Medication: _____Exp. Date: _____
Dosage: _____Route:_____ Frequency:_____
Specific times to be given at school as needed for:_____

Medication: _____Exp. Date: _____
Dosage: _____Route:_____ Frequency:_____
Specific times to be given at school as needed for:_____

ALL PRESCRIPTIONS AND OVER-THE-COUNTER MEDICINE TO BE PROVIDED BY PARENT.

I authorize my child's school nurse or delegate to administer the above medication(s) to my child during the school day. I agree to hold West Sabine ISD, its employees, and delegates who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication(s) at school. Also in the event this medication is stopped or any changes are made in the administration of this medication, I will immediately notify the school. If the discontinued medication is not picked up by me within the school year, I give permission for it to be discarded/destroyed. I understand that expired medication will not be administered, but will be discarded/destroyed. I also understand to provide medication that is appropriate for my child's age.

_____ _____ _____ _____

Parent/Guardian Signature Relationship Date Reviewed by Nurse

Per FFAC (local) and FFAC (legal) WSISD Policy