Bryan ISD Nursing Services
Parent/Guardian Consent to Administer Medication

Student Name:	Date of Birth:	School ID #:

I give permission to Bryan ISD clinic staff and other designated staff members to administer the following medication to my child, according to the printed prescription label instructions or package instructions of over-the-counter medications.

Medication:	Strength:	Dose:
Approximate time to be given:	Prescribing Doctor:	Drug Allergies:

Parent/Guardian Signature:	Date:
Printed Parent/Guardian Name:	Phone:

Date	Count	Signature #1	Signature #2	Comments	Date	Count	Signature #1	Signature #2	Comments

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