

# West Houston Charter School

Mr. Reginald Johnson  
Headmaster

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## AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL

Date: \_\_\_\_\_

Please complete the following if the medication named below is to be given during school hours in order to keep this child in optimal health and help maintain school performance.

**NAME OF STUDENT:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_

Diagnosis or Reason for Medication: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage and Time: \_\_\_\_\_

Common Side Effects: \_\_\_\_\_

Physician section only required for prescription medications.

\*\*\*\*\*

**PHYSICIANS:** Please sign and return to the parent or the school as soon as possible.

\_\_\_\_\_  
Physician's Name (print or type)

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Fax Number

\*\*\*\*\*

**PARENTS:** Please complete the following:

*I hereby give permission to West Houston Charter School to administer the medication listed above to my child, as requested by me or the above physician.*

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Fax Number