

MEDICATION POLICY

TO: Officials of Bynum Independent School District

I hereby order the administration of the following medication in the dosage described and at the times indicated below to:

(Name of student)

Name of medication: _____

Dosage and times of administration: _____

Duration of therapy: _____

Parents Signature: _____

Date: _____

NOTE: Parents must complete this form and return it to the school before any medication may be given by the school officials. The name of the medication to be given and the amount must be stated. All medication must be in the original bottle/container with the label attached. This includes Tylenol, Advil or any other medication your child may need during the school year.

Date received at school: _____ by: _____