

West Houston Charter School

Mrs. Brenda Davidson

Principal

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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