Over the Counter or Short Term Prescription Medicine;

Date: _____ Teacher: _____

I request and give permission to Moody ISD to administer the following medication

to my child _____ for _____.
(Child's first and last name) (Illness or condition)

- Drug Name: _____
- Dosage or how much: _____
- Frequency or time: _____
- Parent will pick up medicine at the end of each school day? Yes. ____
  (No medicine will be sent home with students.) No, keep at school. ____

Parent or Guardian Signature: X_____

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