NORTHSIDE INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT

Short Term Medication Form

Date: _____

Name: _____

Teacher: _____

Grade: _____

To School Nurse and/or Office Staff

Please administer the following medication to my child as indicated:

Medication: _____

Dosage: _____

Time: _____

For (circle days):

14 days
10 days
7 days
5 days
Today only
Other _____

Note: The Short Term Medication Form is good for a Maximum of two weeks.

_____
Parent/Guardian Signature

All medication must be in the original prescription bottle. No over the counter medication is given without a doctor's order and must be in a new unopened bottle.