

MARION INDEPENDENT SCHOOL DISTRICT

Student Personnel

Series 500

Policy Title ADMINISTRATION OF MEDICATION TO STUDENTS

**Additional Authorization for medication prescribed for
ADD/ADHD:**

Student name _____

Grade _____

Birthdate _____

I give permission to the Marion Independent School District to complete Behavior Checklists to help monitor medication administered to the above named student. I understand the checklists will be completed at least twice a year and two weeks after any dosage changes. I request the checklists be sent to the following physician and me.

Physician _____

Address _____

Phone _____

This permission is good for one year from the date signed below. I may cancel permission by giving written notice to the Marion Independent School District and the physician listed above.

Parent Signature _____ Date _____

Medication/Dosage to be monitored _____