MIDLAND INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT

Physician Permission for Student to Carry and Self-Administer

ORAL CONTRACEPTIVE (Birth Control)

Student Name: _____ DOB: _____

Homeroom Teacher: _____ Grade/Student ID#: _____

Home #: _____ Work #: _____ Cell #: _____

Emergency Contact: _____

Home #: _____ Work #: _____ Cell #: _____

PRINT Parent /Guardian First and Last Name _____

Parent/Guardian Signature _____

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This student has been instructed in the proper way to use her medication(s) and understands that these medications cannot be shared with any other person.
Parent initials_____

Student Signature:_____Date:_____

Medication Name: _____ Dose: _____

When to use: _____

Where will medication be stored on trip? _____

Additional instructions: _____

Prescribing Physician's Name: _____

Date: _____ Office #: _____ Fax #: _____

Rev. 03/31/2016