

REQUEST TO ADMINISTER MEDICATION AT SCHOOL
USD 356 CONWAY SPRINGS KS

Name _____ Birthdate _____

School _____ Grade _____

Medication _____ Dosage _____

School time schedule of administration _____

Date started _____ Expected duration _____

Diagnosis/Comments _____

Physician's signature _____ Date _____

Printed Name _____ Office phone number _____

PARENTS: I hereby certify that _____ has previously had at least one dose of the above-prescribed medication and did not have an adverse reaction from it. I request that this medication be administered at school as directed above. I understand that any school employee who administers this medication to my child, in accordance with written instructions from the physician or dentist (& BOE policy) shall not be liable for damages as a result of an adverse drug reaction suffered by the pupil because of administering such drug or because of mislabeled or altered product. I hereby authorize the USD #356 school nurse to exchange information regarding this request with the above named attending physician.

Signature of Parent or Guardian

Date

NOTE: The medication is to be brought to school in the original container appropriately labeled by the pharmacy, stating the name of the medication, the student and doctor's name, the dosage, and times to be administered. Students in grades 6-12 may carry inhalers with them provided they have written parental and physician approval. Age appropriate over-the-counter medication may be given without a physician's signature. A parent or guardian's signature is required. The medication must be in the original container.