REQUEST TO ADMINISTER MEDICATION AT SCHOOL

PRESCRIPTION MEDICATION

USD 356~CONWAY SPRINGS, KS~FAX # 620-456-3312

For your child's safety, the medication must:

- Have the first dose given at home to avoid unexpected reactions.
- Be in the original container labeled appropriately stating the name of the medication, the dosage, and the manner to be given at school.
- Written consent must be given by a parent or guardian and also signed by a physician.
- A new medication form must be filled out for each new school year.

Name_____Birthdate_____

School_____Grade_____

Medication_____Dosage_____

School time schedule of administration_____

Date started_____Expected duration_____

Reason for Medication_____

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 named attending physician.

_____ _____

Signature of Parent or Guardian Date

Physician

_____/_____

Physician's name printed Physician's signature

_____

Physician's address

_____/_____

Physician's Telephone Number Physician's Fax Number